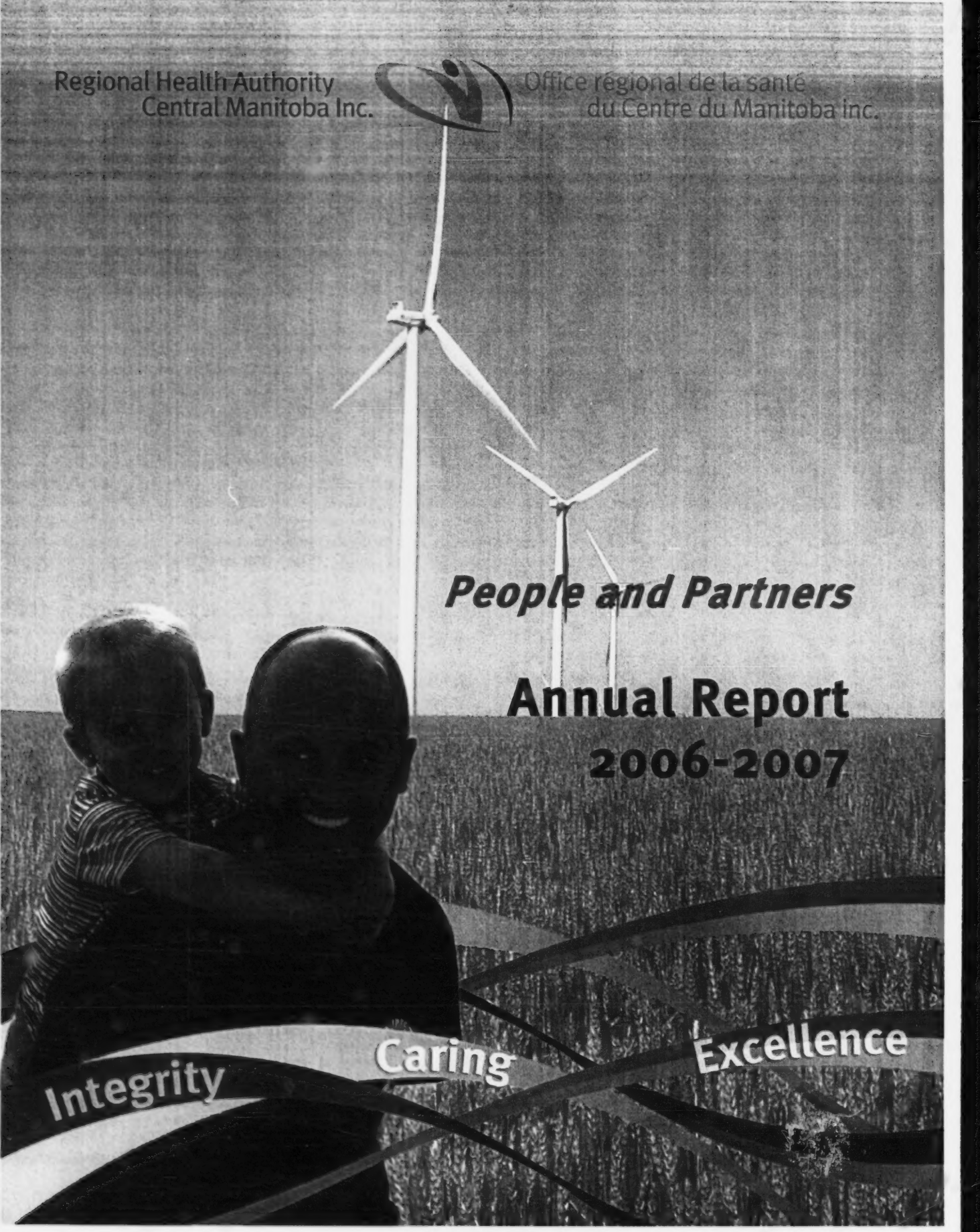

Regional Health Authority
Central Manitoba Inc.
Office régional de la santé
du Centre du Manitoba inc.
People and Partners
Annual Report
2006-2007
Integrity
Caring
Excellence

Working for RHA Central, I experience, or witness *integrity, caring* and *excellence* when I . . .
See constant changing and evolving health services for the people of our communities. The change/evolution is being responsive to our clients.

Pat Nodrick, Portage

Working for RHA Central, I experience, or witness *integrity, caring* and *excellence* when I . . .
Visit clients and their faces light up because we are an integral part of their lives keeping them at home.

Nicole Comte, Notre Dame

Working for RHA Central, I experience, or witness *integrity, caring* and *excellence* when I . . .
Observe the staff in our health centre everyday...our residents are treated with respect and caring everyday. Everyone works together as a team.

Linda Pearce, Manitou

As part of the RHA Central organization, volunteers . . .
The depth & breadth to the 'caring' provided by the Region. Volunteers also add value by making the experience of those receiving care better.

Jennifer Baker, Portage

In envisioning the RHA Central's future, I look forward to . . .
Utilizing all agencies/facilities to their full potential. My dream would be that constituents would feel they could trust any facility within the Region to provide an excellent level of care. I look forward to clear, concise direction. The expansion of Telehealth provides enhanced services clinically.

Linda Buhr, Boundary Trails

ver Photo : regards to Dr. Gary Malenchak and son Jeremy.

Table of Contents

An abridged copy of this report is available in French upon request from the Regional Health Authority – Central Manitoba Inc.

La version française (abrégée) du rapport annuel est disponible sur demande au bureau de l'Office régional de la santé du Centre du Manitoba inc.

Regional Health Authority
Central Manitoba Inc.

Office régional de la santé
du Centre du Manitoba inc.

Letter of Transmittal

September 26, 2007

The Honourable Theresa Oswald
Minister of Health
Room 302, Legislative Building
Winnipeg, Manitoba
R3C 0V8

Dear Minister,

On behalf of the Board of Directors of Regional Health Authority – Central Manitoba Inc. (RHA Central), I respectfully submit our 2006 – 2007 Annual Report. The document was prepared under the direction of the Board of Directors in accordance with the Regional Health Authorities Act and directions provided by the Minister of Health. All material, economic and fiscal implications known as of March 31, 2007 have been considered in preparing the Annual Report.

The RHA Central continues to remain focused on Manitoba Health's Vision of "Healthy Manitobans through an appropriate balance of prevention and care."; and as well as Manitoba Health's goals:

- Optimize the health status of all Manitobans through prevention and health promotion
- Improve quality, accessibility and accountability of the health system
- Achieve a sustainable health system.

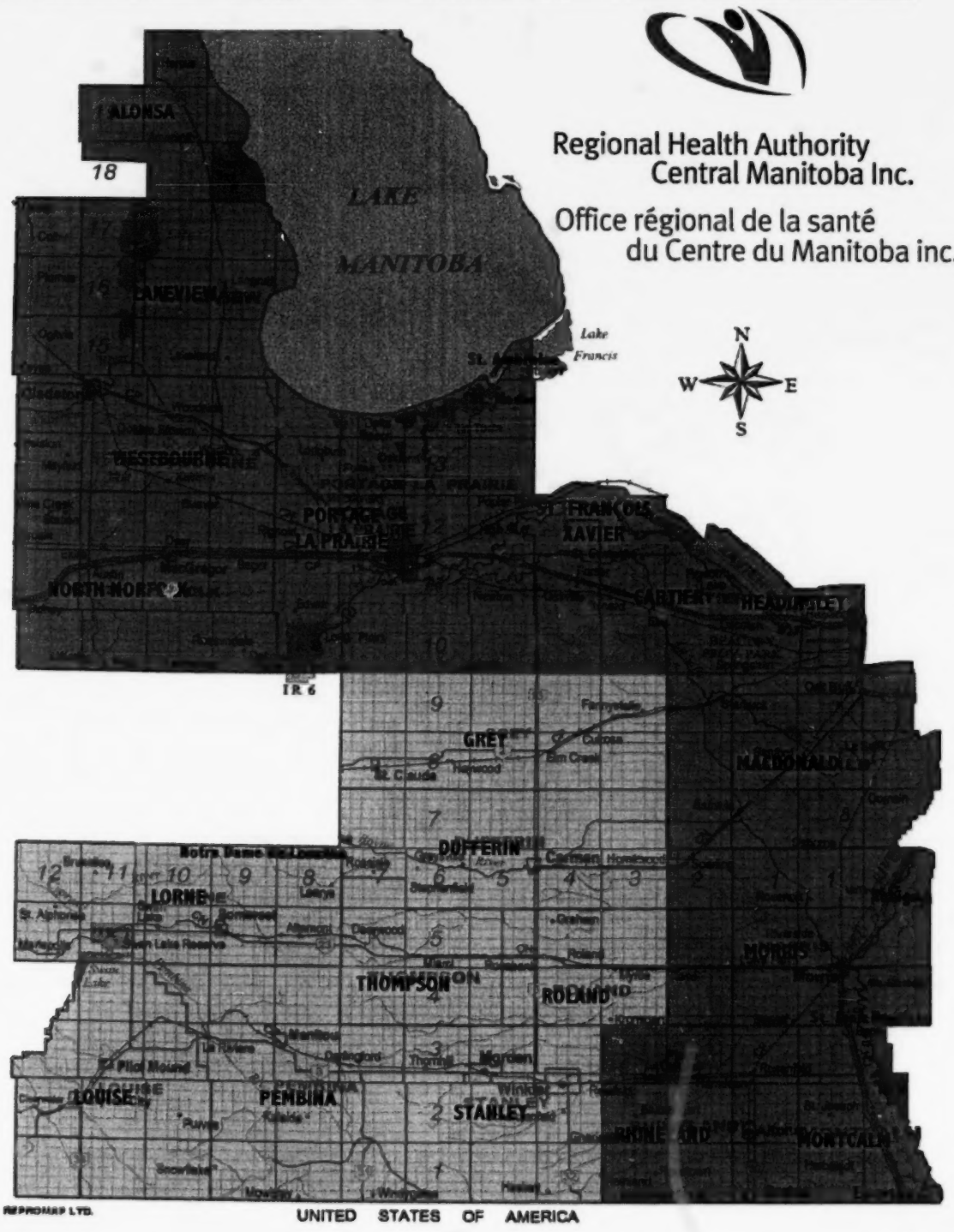
We anticipate you will find this a comprehensive report of the 2006-07 achievements and direction of RHA Central Manitoba Inc. as we strive to be "as healthy as (we) can be at a reasonable cost to the community".

Sincerely,

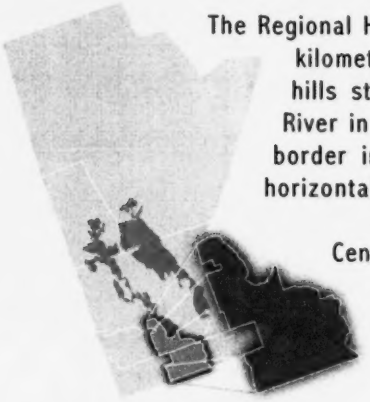
C. Gretsinger

Connie Gretsinger
Board Chair
Regional Health Authority – Central Manitoba Inc.

Central Region Map



Central Region Profile



The Regional Health Authority - Central Manitoba Inc. extends over 18,900 square kilometres of south-central Manitoba. Its backdrop of rivers and rolling hills stretches from the western edge of the Pembina Valley to the Red River in the east, and from Lake Manitoba in the north to the international border in the south, with the Trans Canada Highway crossing the Region horizontally.

Central Region is the most populated of the Province's rural and northern regions with over 100,000 people, 37 municipalities, numerous communities and 8.5% of the Province's total population. Farmland and fields adjoin vibrant communities that bustle as centres of agriculture and industry.

The Chief Executive Officer carries out the Region's mandate, directing and overseeing the activities of more than 3,300 employees and a great many volunteers. In Central Region, there are currently 13 acute care sites, 15 personal care homes, 11 home care offices, 13 public health units, 1 mental health centre, 8 mental health offices, crisis services and the Karen Devine Safe House, 14 Services to Seniors' community resource councils and 14 ambulance stations.

By integrating all health care services, we plan and coordinate our resources to provide the best and most cost-efficient range of services where they are most needed.

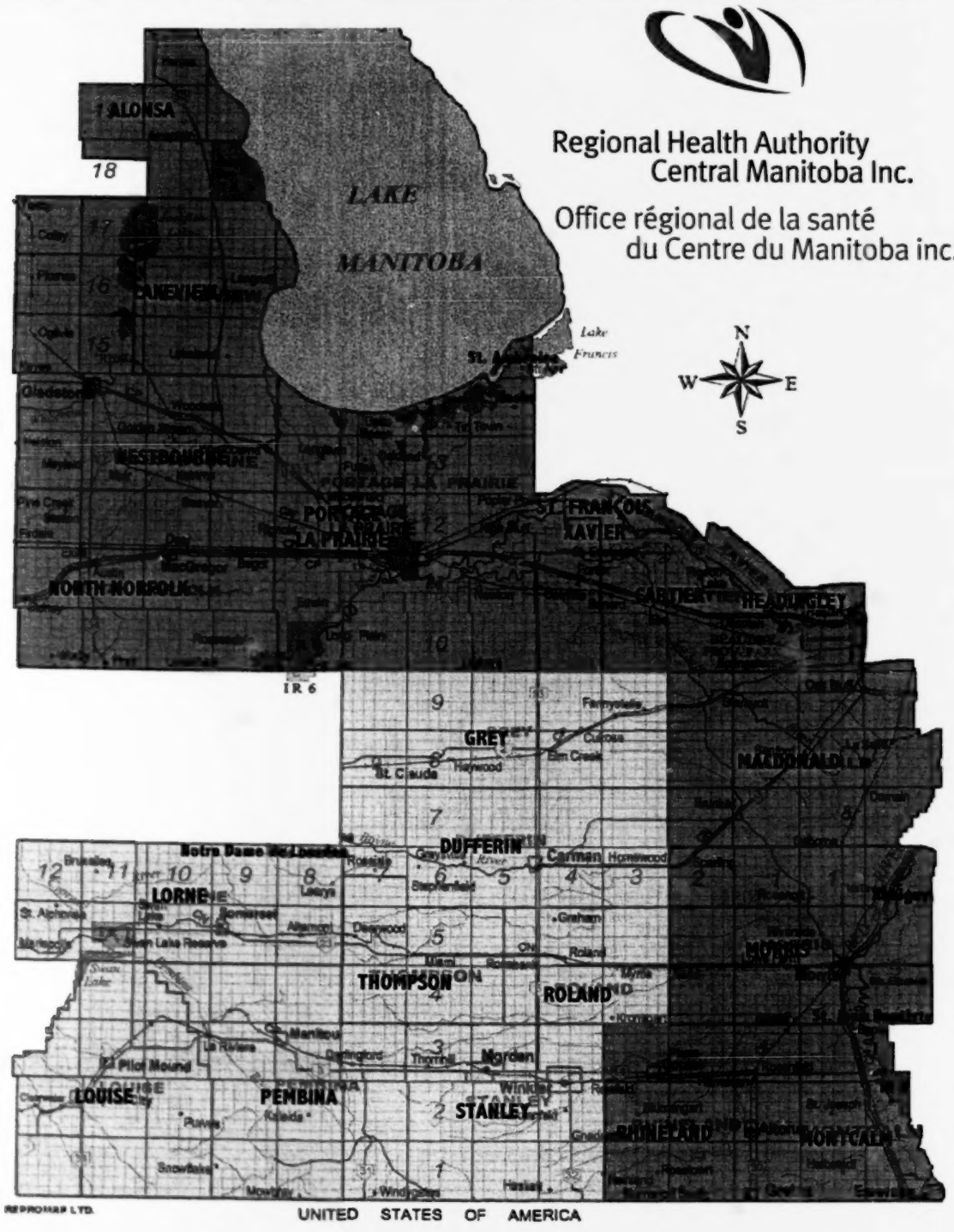
We recognize that RHA Central employees are the most important resource in carrying out our mandate. Guided by our Core Values, Board ENDs, Strategic Health Plan, and Community Health Assessment, we are committed to the personal wellbeing and professional development of our staff.

As we contemplate the journey ahead and make decisions as to where we should focus our energies and resources in the coming years, we continue our ongoing commitment to having people in our Region AS HEALTHY AS CAN BE!

As part of the RHA Central organization, volunteers are . . .
The backbone and unsung heroes of every community.

Sylvia Ptashnik, Carman

Central Region Map



Central Region Profile

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As part of the RHA Central organization, volunteers are . . .
The backbone and unsung heroes of every community.

Sylvia Ptashnik, Carman

Governance

The Regional Health Authority – Central Manitoba Inc. exists so that people in our Region are as healthy as they can be at a reasonable cost to the community.

The RHA Central is governed by a Board of Directors, members of which are appointed by the Minister of Health in accordance with provisions of The Regional Health Authority Act. They are responsible for implementing and establishing a sustainable, integrated system of health services by:

- Providing leadership in addressing the health needs of the population within the defined geographic boundaries of the Region;
- Assuming full Board responsibilities and attending meetings on a regular basis;
- Communicating effectively with the Board, management and the people in the Region; and
- Being accountable for directing the management and affairs of the Regional Health Authority.

In envisioning the RHA Central's future, I look forward to . . .
Being a part of the future here because I feel we are offering an integral part in the physical and emotional health of our residents.

Pat Sayer, Carman

Governance (con't)

Currently, 13 Board Members oversee the direction and management of the RHA Central.

In performing its job, the Board:

1. Provides accountability for activities of the RHA Central to the residents of the Region and ensures that the organization is in compliance with the laws, rules and regulations that govern it.

2. Develops written governing policies.

3. Assures Chief Executive Officer performance is achieving the results through monitoring.

4. Develops statements of principles and positions related to public policy which represent the health interests of RHA Central's residents.

The Board has established various structures and processes that allow it to function in accordance with its responsibilities. The Board meets on the fourth Wednesday of each month, except in July, in various locations across Central Region. The meetings are open to the public and both the agenda and meeting minutes are posted on the RHA Central website.

The Board has five standing committees: the Executive Committee and the Finance Committee which function as committees of the whole, the Audit Committee, the Leadership and Partnership Committee and the Policy Review Committee. The Board also appoints a Medical Advisory Committee (MAC) Liaison Board Member and establishes ad hoc committees to deal with particular issues, as the need arises.

Board of Directors

CONNIE GRETSINGER, CHAIR
(Portage la Prairie)

ALBERT SCHMIDT, Vice-Chair
(Altona)

CÉLINE BEAUDETTE
(St. Jean Baptiste)

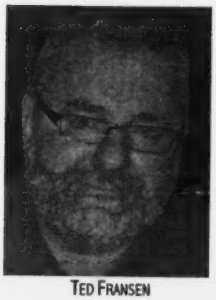
ERIC CAMERON
(Swan Lake)

ELIN CZERANKO (Langruth)
Appointed March, 2007

RALPH CIBULA
(Gladstone)

KENNETH CRAWFORD (Portage la Prairie)
Appointed March, 2007

NORBERT DELAQUIS
(Notre Dame de Lourdes)



TED FRANSEN
(Morden)

ROBERT JONES (Winkler)
Appointed March, 2007

ROGER KIROUAC
(La Salle)

JEANNIE MARION
(Morris)

DAREN VANDENBUSSCHE
(Portage la Prairie)

JOHN KRAHN, Chair (Winkler)
Term Ended (March, 2007)

BOB MCKENZIE (Carman)
Term Ended (March, 2007)

JOANNE ROULETTE (Marius)
Term Ended (March, 2007)

Message from the Chairperson

The job of the Board of Directors is to make contributions, through its unique trusteeship role, which leads the organization toward the desired performance, so that people in Central Region are as healthy as they can be at a reasonable cost to the community.

Strategic Direction

The strategic planning of the Board consists in determining ENDs: strategic directions or outcomes to be achieved for the RHA Central as well as in defining Executive Limitations. Linking with people in Central Region through regularly scheduled interactions in the community, the Board gathers information and considers the impact on its own strategic plan. Strategy therefore begins with "ownership linkage".

- In April 2006, the Board reviewed information received from focus groups held throughout the Region to encourage dialogue on what "at a reasonable cost" means in the context of the RHA Central's broad statement of purpose or Board END. The resulting definitions were shared at the Annual Public meeting in October 2006.
- The Board hosted a Leaders' Forum "Creating a Partnership: Education & Health Working Better Together for Kids" to begin a dialogue among leaders within the Region's health and education systems about their potential to collaborate more effectively to enhance the lifelong health and the educational attainment of the children of the Central Region. Fifty-one people participated in the forum. In addition to participation from the Manitoba Centre for Health Policy, twenty representatives from the school divisions participated. They comprised of superintendents, assistant superintendents, senior staff and board trustees drawn from all nine school divisions located in Central Region. As well, one representative was present from the Healthy Child Coalition and three representatives were connected with the Families First program. This Forum was the beginning of a process of continuing dialogue, with identified strategic directions and hopes that it would evolve into a common approach.
- In June and September 2006, five focus groups conducted by Cynthia Carr, Epidemiologist, and Board Members were held with seniors from Gretna, Gladstone, Darlingford, St. Claude and First Nation Community representatives in Portage la Prairie. There were 27 participants in these focus groups. The questions asked intended to reaffirm the Board ENDs with seniors living in the community.
- Representatives from the community of Gladstone shared information regarding human resource issues currently affecting Seven Regions Health Centre and Third Crossing Manor.
- The Board seeks input from stakeholders through community forums that meet regularly to share information and issues of concern. The Board also engages stakeholders with timely communications, the Annual Public Meeting in October, a newsletter circulated to all households in Central Region twice a year, media interviews and open and timely responses to media enquiries and the Authority's website, which was under construction in 2006-07.

Working for RHA Central, I experience, or witness *integrity, caring* and *excellence* when I . . .
Network with others across RHA Central. These values exist and are apparent in all that we do. I am proud to belong to Central Region.

Kristal McKitrick-Bazin, Crystal City

From the work of the Board, staff has further defined its understanding of the Board's direction and developed strategies/actions to accomplish the Board ENDs as articulated in the Five-Year Strategic Health Plan "2006-2011, The Journey Ahead". The interpretation describes outcomes in greater detail and identifies specific priorities. An annual health plan has been then developed each fiscal year, wherein the CEO aligns resources and priorities with the Board ENDs and strategic health plan.

A key strategic responsibility of a Board is to appoint and oversee the operation of the Chief Executive Officer (CEO). The RHA Central experienced an exceptional transition in terms of its senior leadership. Early in 2006, Mr. Neil Walker advised he would step down as CEO, effective July 31, 2006 to become Chief Operating Officer, Markham-Stouffville Hospital in Ontario. Wishing him well, the Board immediately proceeded to appoint Mr. Helmuth Klassen as the acting CEO, effective August 1, 2006. The Board was delighted that he accepted this responsibility and we are happy that he provided direction to the organization during his tenure. A Search Committee was established, and then in March 2006, the Board enthusiastically welcomed the new CEO, Kathy McPhail. Her proven leadership ability combined with her experience and educational background make her an outstanding choice for this position. Already Ms. McPhail's strong leadership, interpersonal and management skills have proven invaluable in moving our Region forward.

Board Performance

The Board has established mechanisms to continually evaluate the effectiveness of our performance:

- The Board has written policies that describe its own actions and processes used in governance. In 2006-07, we established the Policy Review Committee to review all Governance Process, Board-CEO Linkage, and Executive Limitations policies as well as the Board bylaws. The committee is also charged with elaborating performance indicators for monitoring the policies.
- The Board monitors itself for its results and practices against its own policies at each Board meeting in accordance with an approved calendar. Additionally, each Board meeting is assessed by the participants, and reported back at the following meeting.
- With the assistance of a consultant, the Board discussed various approaches to enhance Board effectiveness. These were revisited in May 2006.
- To assure governing with excellence, the Board invests in its governance capacity through education. New Board Members have the opportunity to attend both an internal orientation session as well as at a provincial gathering where they receive extensive background material. All Board Member(s) attending Provincial / National conferences provide a written report summarizing the event to share knowledge with the Board. The Board plans its educational requirements at the beginning of each year. In 2006-07:
    - ✓ Mrs. Joanne Roulette, Board Member, gave a presentation that illustrated the effects of history/change upon First Nation people together with the barriers which often lead to misunderstandings.
    - ✓ Mr. Stan McKay was invited to a Board meeting to speak on the topic of 'Inclusiveness in a Pluralistic Society'.
    - ✓ A presentation on the recruitment of physicians and the process involved before a physician may practice in the Province of Manitoba was given by the Regional Chief of Staff, Dr. Fortier.
    - ✓ The Healthy Communities Conference, April 21, 2006 and the Palliative Care Conference, September 2006 were hosted by RHA Central, with attendance by Board Members.
    - ✓ Board Members also attended the Rural and Northern Health Care Meeting and the Canadian College of Health Services Executives Provincial Health Conference/Forum in October 2006.

This year marks the tenth anniversary of the establishment of the RHA Central. The accomplishments realized over the past year – and over the past 10 years – demonstrate the vision and enterprising nature of People, past and present. To this end, we are grateful for their countless contributions and for making ours an organization we can be justifiably proud of.

As part of the RHA Central organization, volunteers are . . .
Priceless commodities who augment our community program.
Rosemary Pitt, Barb McGillivary, Jodi McLean, Manitou

We salute the staff for their hard work and devotion to meeting the needs of our clients. The progress and achievements of the past ten years is evidence of the amazing dedication, resourcefulness, and incredible talent that exists in our Region. They model our core values of integrity, caring and

excellence every day as they interact with others throughout Central Region and beyond. We want to congratulate Kathy McPhail, our new CEO, as well as Helmuth Klassen, interim CEO in 2006-07, and the entire team, for another year of success.

I wish to acknowledge the members of the Board for their valuable insights, their commitment and thoughtful stewardship through the years. We extend a special appreciation to the members whose terms expired this year. During their tenure, Bob McKenzie and Joanne Roulette championed many projects and their sincerity and determination greatly contributed to the work of the Board. We also offer our heartfelt thanks to John Krahn who took the helm as Chair of the Board of Directors in 2001. His tireless devotion and enthusiastic leadership served the Region well as he led the Board through a significant transition and governance renewal process. He leaves a legacy that will benefit future Boards. To that end, we are please to welcome Kenneth Crawford from Portage la Prairie, Elin Czeranko from Langruth, and Robert Jones from Winkler as new members of the Board.

As we reflect on this milestone anniversary, we would like to express our deepest appreciation and recognition to the volunteers, foundations, auxiliaries and communities and all those who give so generously to support the many programs and services in the RHA Central. We are so fortunate in having individuals and organizations that are truly passionate about making a difference in our communities by engaging in a variety of events and activities supporting health care in our Region. I believe that their gifts of time, skill, effort and inspiration enrich our health care resources "so that people in Central Region can be as healthy as they can be".

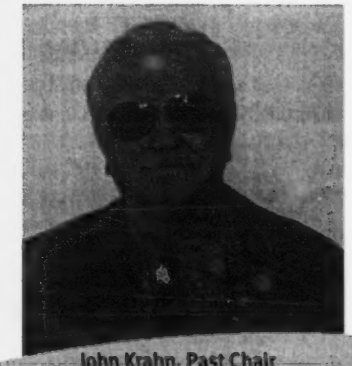
I am gratified to be part of such an outstanding organization – an organization that matters to so many, not only in Central Region, but across Manitoba. I am confident that with its People and Partners the RHA Central will continue to see remarkable progress in the next decade.

I would also like to thank the Honourable Theresa Oswald, the Minister of Health, for her continued support and encouragement.

Sincerely,

C. Gretsinger

Connie Gretsinger
Board Chair
Regional Health Authority – Central Manitoba Inc.



John Krahn, Past Chair
Term ended March 31, 2007

Message from the CEO

Kathy McPhail
Chief Executive Officer

I am honored to present the Regional Health Authority – Central Manitoba Inc.'s (RHA Central) Annual Report for 2006-2007. While I only began my tenure in March 2007, serving for the last portion of the fiscal year to which this annual report pertains, I have had the opportunity to recognize and value what has been accomplished in Central Region.

In so doing, I would be remiss in not mentioning the contributions of Mr. Helmuth Klassen whose willingness to share his leadership skills as interim CEO during the search process and beyond was an invaluable gift of service to the Region. He was and continues to be an integral part of the leadership team already in place before my arrival and has our appreciation and gratitude for his commitment to RHA Central.

This fiscal year marks the end of ten years since the establishment of regional health authorities and, as we stand on the threshold of the RHA Central's second decade, we reaffirm our commitment to our core values of integrity, caring and excellence. RHA Central's future will continue to be built with the support and collaboration of staff, physicians, volunteers, communities, supporters, colleagues and others working together.

Indeed, the story of the RHA Central in the last 10 years is the story of **People and Partners** and their enduring commitment:

We celebrate our staff, a vital source of organizational energy that fuels our drive to create and explore new ideas. With unparalleled resolve and fortitude, over 3,300 health care providers continually challenge themselves to excel in their everyday practices to offer the best service possible, and this, in times of unprecedented transition and change. At the front line in all our endeavors, staff and physicians have shown remarkable flexibility, courage and ingenuity, acting with compassion and concern for the wellbeing of others and continuously striving for improvement. They are the lifeblood of our organization and I commend them for their professionalism and devotion to Central Region.

We celebrate our volunteers, foundations and auxiliaries and marvel at their incredible generosity over the years. By contributing their time, energy, and talents they truly make a difference. As a result, their dedication, and collaborative spirit are the drivers of many of our accomplishments and are an integral part of the health care system.

Working for RHA Central, I experience, or witness *integrity, caring* and *excellence* when I . . .
Come to work each day...there are small acts of kindness and caring that occur daily alongside heroic acts that save lives which reinforces the excellent quality of care that thrives in our Region.
Wendi Sofillas, Boundary Trails

We celebrate our communities.
Communities represent the true diversity of Central Region.
Their tenacity and collective wisdom pave the way for strategic planning efforts as we continue to dialogue. We celebrate the leadership they have demonstrated through the years.

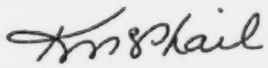
We celebrate our partnerships and seek to link with those who share our values. Our ability to cultivate and maintain productive and collaborative relationships with others fosters an environment for innovation, diversity, a sense of

mutual responsibility, and organizational effectiveness. During times of significant change, partnerships become a progressive means for sustaining and nurturing common service needs beyond the scope of individual organizations. Working alone, we cannot hope to meet the challenges of a fast paced electronic world. We need to build bridges and discover the power of working together with others.

We celebrate the Board of Directors, who, on behalf of people in Central Region, has invested time and effort in developing an effective and accountable governance structure. As community stewards, they demonstrate leadership in their linkage activities and are thus the organization's major strategic compass. It bears repeating that the Canadian Council on Health Services Accreditation (CCHSA) confirmed in its March 2006 Survey that 'persons served within the Region feel that they are well cared for and are listened to'. While I have only been with the RHA Central for a short while, I have found the Board to be dynamic and engaged. They aim to be explicitly accountable for their work and for setting designing of the RHA Central ENDs/Purpose which set the direction for our organization to achieve the desired outcomes.

It is with great pride and joy that I begin my tenure as CEO of the RHA Central. Realizing that our individual and collective efforts are of great value to those we serve, we can indeed celebrate the progress that has been made by the many individuals and partners who have worked with the RHA Central throughout its first ten years of operation. As outlined in the following pages, we face many daunting challenges. We will be engaging with the People and Partners in addressing those challenges and seize the many opportunities before us! In turn, we will continue to grow stronger together through our collaborative partnerships.

Respectfully,

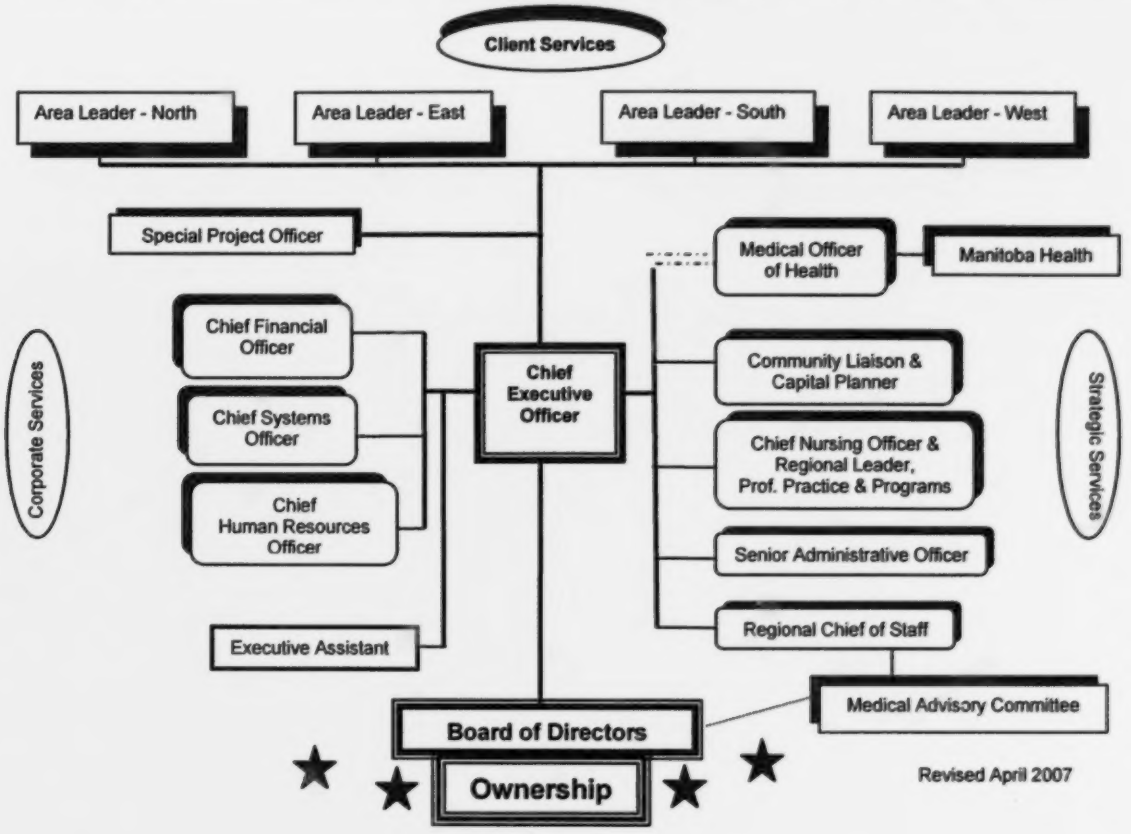


Kathy McPhail
Chief Executive Officer
Regional Health Authority – Central Manitoba Inc.

In envisioning the RHA Central's future, I look forward to . . .
Seeing younger leaders developing skills and accumulating experience to provide stable leadership for the future.

Helmuth Klassen, Winnipeg
Interim CEO (Aug/06-Feb/07)

Organizational Structure



The 2006-07 fiscal year saw significant leadership change. The Board of Directors announced in May 2006 that Neil Walker was stepping down as Chief Executive Officer (CEO), and appointed Helmuth Klassen as Acting CEO effective August 1, 2006 until such time as a permanent CEO was hired.

Prior to Christmas, the Board formally announced the appointment of Mrs. Kathy McPhail as Chief Executive Officer of the Region, effective March 1, 2007.

At the next level of the organization, three of the four Area Leader senior management positions, with collective experience totalling over 98 years in the Region, were vacated due to retirements of long-time service staff in April, October and December 2006. These positions were held by Mrs. Carol Hildebrand, Mrs. Jacqueline Théroux and Mrs. Winnie Pauch respectively. All three senior management vacancies were filled from within our organization. An appointment announcing Mrs. Jane Curtis as Area Leader East was made effective August 28, 2006; Mrs. Cheryl Harrison began her new role on October 2, 2006 as Area Leader West and Mrs. Mary Smith accepted her position as Area Leader North effective March 5, 2007.

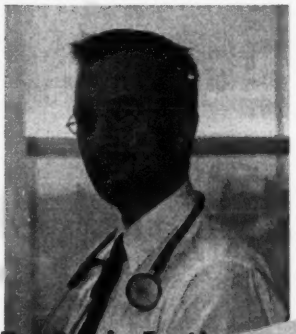
In addition to the Senior Management Team and members of the Regional Leadership Team comprise both Program & Practice Leaders who provide strategic direction to the organization on matters of policy, practice and budgeting, and the Community Integrated Health Services Leaders/Integrated Community Services Leaders/Integrated Support Services Leaders, who manage the day-to-day activities of staff throughout the Region.

Contract Health Corporations

Prairie View Lodge	Ginger Collins
Rock Lake Health District Hospital	Ginger Collins
Rock Lake Health District Personal Care Home	Ginger Collins
Tabor Home Inc.	Sherry Hildebrand
Salem Home Inc.	Sherry Janzen
Eden Mental Health Centre	Les Zacharias
Eden Mental Health Services	Eckhard Goerz

Regional Medical Advisory Committee

The Chiefs of Staff from each medical group meet together regularly to monitor reports and to provide direction about medical practice issues, be they standards, pharmacy and therapeutics, diagnostics, medical staff by-laws or reviewing credentials and recommending privileges to the Board.



Dr. Denis Fortier
Regional Chief of Staff

Dr. Denis Fortier, Chair
Dr. Eva Berman Wong
Dr. Harold Booy
Dr. Shelley Buchan
Dr. Dieter Bueddefeld
Dr. Michael Dyck
Dr. David Kinnear
Dr. Robert Kruk
Dr. Ann Loewen
Dr. Ockie Persson
Debbie Nelson, Chief Nursing Officer & Regional Leader, Professional Practice and Programs
Helmuth Klassen, Community Liaison & Capital Planner
Connie Gretsinger, Board Medical Liaison

Management

Kathy McPhail	Chief Executive Officer
Ken Klassen	Chief Financial Officer
Claudette Lahaie	Senior Administrative Officer
Dr. Shelley Buchan	Medical Officer of Health
Martin Montanti	Chief Systems Officer
Jim Hunter	Chief Human Resources Officer
Helmuth Klassen	Community Liaison & Capital Planner
Debbie Nelson	Chief Nursing Officer & Regional Leader, Professional Practice and Programs
Dr. Denis Fortier	Regional Chief of Staff
Jane Curtis	Area Leader – East
Mary Smith	Area Leader – North
Lorinda Schramm	Area Leader – South
Cheryl Harrison	Area Leader – West

Programs/Services Leaders

Aboriginal Health – Jennifer Baker

Child & Adolescent Health – Jane Curtis

Corporate Communications – Lorraine Grenier

Critical Care/Medicine /Surgery – Eileen Vodden

Diagnostic Services – Mark Anderson

Electronic Health Records – Shelley Barnes

Emergency Medical Services – Corene Debreuil

Emergency Preparedness– Larry Skoglund

Finance –Kathy Klassen

Food Services – Lori McFarland

Health Information/Privacy & Access – Susan Enns

Healthy Living/Primary Health Care– Jennifer Baker

Human Resources

- Recruitment & Retention – Jenn Sager-Hlady
- Workplace Health & Safety – Bev Wood/Cindy Joel
- Labour Relations – Ardith Rothwell

Infection Control – Kim Dyck

Information Technology – Shaun Twist

Mental Health – Ken Kroeker

Nutrition & Diabetes – Chantelle D'Andreamatteo

Palliative Care – Paulette Goossen

Payroll – Sheldon Hildebrand

Pharmacy Services – Shawn Bugden

Physical Resources & Environmental Services – Terry Hills

Public Health – Stephanie Verhoeven

Quality Improvement/Risk Management – Kristine Hannah

Regional Rehabilitation – Sheila Hay

Seniors' Health – Jan Marie Graham

Special Projects – Carol Garnham

Staff Development/Staff Health – Kim Dyck

Women's Health – Stephanie Verhoeven

Community Leaders

EAST	Altona	**Community Integrated Health Services Leader** – Edith Calder *Altona Community Memorial Health Centre*
	Emerson	**Community Integrated Health Services Leader** – Paulette Goossen *Emerson Health Centre*
	Morris	**Community Integrated Health Services Leader** – Brad Street *Morris General Hospital* *Red River Valley Lodge*
	Rosenort	**Community Integrated Health Services Liaison** – Grace Klassen
NORTH	Gladstone	**Community Integrated Health Services Leader** – Dorothy Doell *Seven Regions Health Centre* *Third Crossing Manor*
	MacGregor	**Community Integrated Health Services Leader** – Sharon Stewart *MacGregor Health Centre*
	Portage	**Integrated Client Services Leader (Acute, Mental Health & Public Health)** – Pat Nodrick **Integrated Support Services Leader (Portage)** – Terry Hills **Portage Seniors' Integrated Client Services Leader** – Bev Boyd *Douglas Campbell Lodge* *Lions Prairie Manor* *Portage District General Hospital*
SOUTH	Crystal City/ Pilot Mound	** Prairie View Lodge* ** Rock Lake Health District Hospital* ** Rock Lake Health District PCH*
	Manitou	**Community Integrated Health Services Leader** –Linda Pearce *Pembina Manitou Health Centre*
	Morden/Winkler	*Boundary Trails Health Centre* **Integrated Client Services Leader** – Linda Buhr **Integrated Support Services Leader** – Kristy Radke ** Tabor Home Inc.* ** Salem Home Inc.* ** Eden Mental Health Centre*
WEST	Carman	**Community Integrated Health Services Leader** –Sylvia Ptashnik *Carman Memorial Hospital* *Boyne Lodge*
	Notre Dame	**Community Integrated Health Services Leader** – Beth Faux *Foyer Notre Dame* *Notre Dame Hospital*
	St. Claude	**Community Integrated Health Services Leader** – Mona Spencer *St. Claude Health Centre (Hospital/Pavilion)*
	Swan Lake	**Community Integrated Health Services Leader** – Kristal McKitrick-Bazin *Lorne Memorial Hospital*

* Contract Health Corporations

06/07 Year in Review

Recognizing our Challenges

In today's modern world, rapid advances in technology and health care transform *how long and how we live.* Change is a way of life in our working environment. In many ways, RHA Central's most fundamental challenge is therefore to embrace change while continuing to preserve integrity, caring and excellence as we do so. In the following paragraphs, we will outline some of the challenges and opportunities facing RHA Central.

Demographics

- With the increased average age of the population, the need for services and supports for seniors multiplies.
- While increased immigration enriches the ethnic and cultural diversity of the Region, foreign-born populations may bring with them complex, diverse and often unpredictable needs.[1] We also recognize these may be complicated with cultural barriers to access.
- There is a decreasing population and aging population in some communities.
- Diverse economic status throughout the Region.

Large geographical Region

- 18,900 sq. kilometres
- 2 regional centres – Portage in the North and Boundary Trails in the South
- Most of our Region is rural. Some small communities are getting smaller and larger communities are growing.

Differences in population health status

- When doing a provincial comparison, Central Region residents enjoy a relative advantage in health status over residents in other areas of the Province.
- We have a diverse culture/population dispersed throughout the Region which enriches the cultural and ethnic mosaic. However, different groups face unique health challenges. For example, disparities exist between First Nations health status and other populations in the Region.

Shift in health care from curative to chronic disease management

- Chronic diseases are one of the leading causes of death and disability. Yet they are potentially the most preventable of all health problems.

  (The RHA Central invited guest speaker Marian Walsh, President and CEO of Bridgepoint Health to its annual meeting October 2006. She alluded to the third -- or new frontier -- of modern health care dedicated to chronic disease and its prevention.)

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[1] *Rural Development Institute Working Paper #2005-7*
Manitoba Rural Immigration Community Case Studies, Steinbach

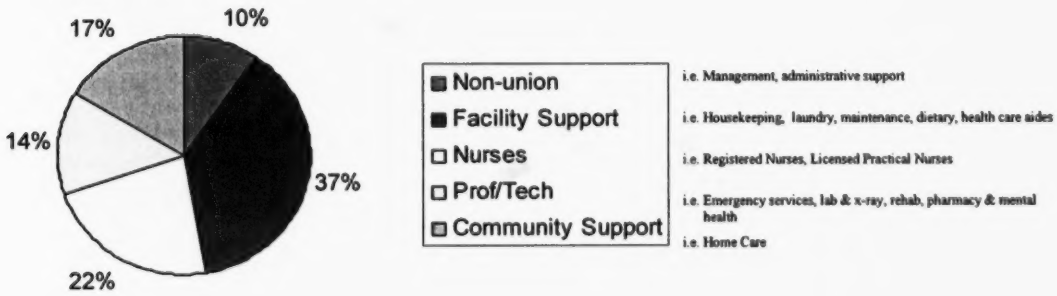
Information technology infrastructure and information management systems

- The management of information across the system is critical to many of our processes and practices. As we seek to keep pace with advancing information technology, we recognize that IT infrastructure needs substantial continuous investment. In addition to maintaining current technology, timely adoption of new technology across the Region is required.
- The ability to move forward with new technologies is an overall area of concern both from a financial and human resource perspective.

Human resources

- The RHA has a skilled, talented and dedicated workforce. Maintaining the high standards of quality and performance of our staff requires a continuing commitment to effective recruitment, training and deployment. However, the RHA also faces continuing challenges in recruiting and retaining sufficient personnel in areas demanding highly-specialized technological skills. Succession planning is necessary but requires resourcing.
- A baby boom echo will filter through our organization. Anticipated mass retirements have generated concern regarding the future supply of new staff.
- Severe shortages in all disciplines have caused curtailments in St. Claude, Emerson, Manitou and MacGregor.
- Change fatigue among health care providers is becoming more prevalent in our rapidly changing system.

Distribution of Human Resources



Fiscal Accountability

- For several years, we have operated in a challenging fiscal environment. The focus remains on providing the quality programs our community requires while ensuring the long-term fiscal viability of the Region. The challenge is to optimize the balance between reducing expenditures and protecting essential functions as well as demonstrating a high level of accountability for both our funding agency and the public.

Capital infrastructure, aging buildings

- Many operational sites struggle with aging infrastructure, however, new construction has contributed to:
  - Emergency Medical Services station in Carman
  - MRI at Boundary Trails
  - Centre Albert-Galliot – Notre Dame de Lourdes ($500,00 capital grant to assist with construction).

The Way Forward

Meeting our Challenges

Four Strategic Pillars

The Regional Health Authority – Central Manitoba Inc. identifies four overarching strategies as means to address its challenges. The strategic 'pillars' support a sustained focus on regional systems and practices and help move the organization forward in a cohesive and integrated fashion.

Strategic Pillar #1

Integrated Health System: Organizational Responsiveness

We interpret 'Integrated Health System: Organizational Responsiveness' to mean a comprehensive, coordinated and seamless regional approach to providing the most appropriate care, by the most appropriate providers, in the most appropriate settings with:

- Equitable access to care throughout life
- A high quality and safe health care system, focused on improved health of our population and sustainability of resources.
- The component parts of the system linking together and participants working collaboratively together to deliver care and services.
- Primary health care as the hub.

As a result, this year we have accomplished...

- ✓ Initiatives to address wait times for total joint replacement and cataract surgery.
- ✓ Pre-hab clinic fine tuned for enhanced patient flow
- ✓ Electronic medical record initiatives
- ✓ Three "support for seniors in group living" projects implemented
- ✓ Children's Therapy Initiative Central Region – common intake process implemented
- ✓ *Équipe de Santé bilingue* team identified for implementation
- ✓ Healthy Communities Conference (annual event)
- ✓ 12 communities host pre-school wellness fairs
- ✓ Ethical decision-making framework in use
- ✓ Region-wide standardized emergency room client education handouts developed and implemented
- ✓ Primary health care initiatives:
    - Physician Integrated Network pilot collaboratives (two pilot sites in RHA Central)
    - Four additional MB-Telehealth sites through French Language Services programming
    - Congestive heart failure Health Links pilot project in Portage la Prairie
    - Telehome Med project through French Language Services programming
    - Training of multidisciplinary teams in the delivery of "Risk Factor Assessment and Complication Assessment" for Diabetes.

Strategic Pillar #2

Healthy Workplace, Healthy Worklife

We interpret 'Healthy Workplace, Healthy Worklife' to mean:

- Core values in action: Integrity, Caring and Excellence
- A wholesome, safe place that provides for effective work practices
- Employee wellbeing
- An organizational culture that supports teamwork and alignment of people and services
- Retention and recruitment competency
- People development
- A learning environment
- Effective succession management processes.

As a result, this year...

- ✓ Cultural competencies have been incorporated as a core competency in Performance Appraisal Program
- ✓ Cultural education is incorporated in new staff orientation and regional training events
- ✓ Aboriginal Workforce Initiative commenced '05-'06
- ✓ Regular offerings of Employee Assistance Program (EAP) sessions
- ✓ Plans implemented to minimize vacancies
    - Secured rotating Licensed Practical Nurse (LPN) training programs
    - Secured LPN to Registered Nurse (RN) program offered through Red River College
    - Dual credit Health Care Aide program with schools and Red River College
    - Recruitment at numerous career fairs and education sites
    - Facilitated student placements for various disciplines within the Region
- ✓ Attendance Management Program in place
- ✓ Management Development Training Program provided
- ✓ Ojibway language lessons offered at Portage District General Hospital
- ✓ French language training offered
- ✓ Staff Worklife Survey completed
- ✓ Employee recognition program expanded and enhanced
- ✓ Respectful workplace policy and education introduced
- ✓ Zero Tolerance for Abuse policy education
- ✓ Disability Management Program and workplace health & safety programs implemented.

Strategic Pillar #3

Partnerships: Building Capacity with clients and community

We interpret 'Partnerships: Building Capacity with clients and community' to mean the development of collaborative relationships with people and organizations to:

- Create new opportunities for strengthening our programs and services
- Better utilize limited resources
- Share knowledge and expertise
- Engage community stakeholders
- Develop an information and resource exchange with academic institutions
- Cultivate a shared sense of responsibility for healthy communities.

As a result, the following provides a sample and range of partnerships...

- ✓ Contract Health Corporations
- ✓ Education/School Divisions
- ✓ Healthy Child Coalition
- ✓ Family Services & Housing
- ✓ Friendship Centre (Portage)
- ✓ Society for Manitobans with Disabilities
- ✓ Rehab Centre for Children
- ✓ First Nation communities
- ✓ Manitoba Métis Federation
- ✓ First Nations and Inuit Health Branch
- ✓ Manitoba Health
- ✓ Communities in Central Region
- ✓ Table de concertation régionale du Centre
- ✓ Société Santé en Français
- ✓ Conseil Communauté en Santé (CCS)
- ✓ Other Regional Health Authorities
- ✓ Diagnostic Services of Manitoba
- ✓ Services to Seniors groups
- ✓ IMPACT Manitoba
- ✓ Royal Canadian Mounted Police
- ✓ Fire departments
- ✓ Manitoba Public Insurance Commission
- ✓ MBTelehealth
- ✓ Colleges and universities in the Province
- ✓ Employment resource centres
- ✓ CancerCare MB
- ✓ Children's Aid Society of Manitoba
- ✓ Women's Shelters
- ✓ MB Patient Safety Institute and Canadian Patient Safety Institute
- ✓ Healthy Child Coalition Manitoba
- ✓ And many other valued partnerships.

Strategic Pillar #4

Performance Improvement: System Competency

We interpret 'Performance Improvement: System Competency' to mean:

- Positive change in capacity, process and outcomes
- Best practices employed throughout the organization
- Timely access to the best data and knowledge available to make the best decisions
- Prioritizing and allocating resources to increase the likelihood of desired health outcomes
- Organization-wide accountability in management of risk, utilization and quality.

As a result, this year we accomplished...

- ✓ Development of preschool wellness fair planning guide
- ✓ Youth health survey planning for implementation 07-08
- ✓ Translation to Ojibway of "It's Safe to Ask" patient pamphlet
- ✓ Mental Health Liaison Nurses in emergency rooms at regional centres implemented
- ✓ Occurrence database implemented
- ✓ Research Ethics Review policy developed and implemented
- ✓ Enhanced primary health care through the development of Wellness Centre model
- ✓ Surgical visioning and planning process established
- ✓ Behavioural therapy services model in community health being developed
- ✓ Falls Management program being implemented
- ✓ Development of hospital information systems project
- ✓ Development of care maps.

In addition to these strategies, the following multiyear performance deliverables will be implemented and monitored

- **Building a Safer System:**
  Patient Safety initiatives will be expanded across the continuum of services
- **Disaster Management:**
  A Regional Disaster Response Plan, including Pandemic will be developed and exercised across our continuum with links to the external agencies.
- **Resource Utilization & System Competency:**
  Utilizing the principles and framework of primary health care, system integration and sustainability, RHA Central will maintain evidence/needs-based service delivery within the Region at 'a reasonable cost to the community'.

Areas of Opportunity

As we continue to address our challenges, we discover occasions to learn from and build on our experiences. The insight gained compels us to:

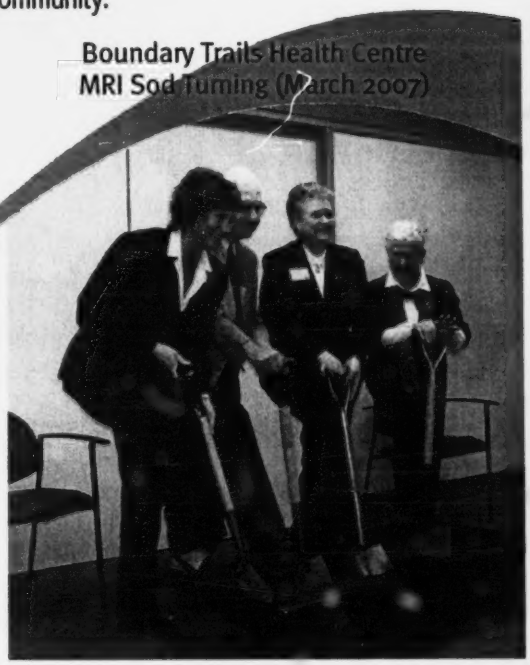
- Continue to collaborate with community stakeholders, recognizing and respecting readiness to change
- Identify our resource needs linked to our goals, activities and outcomes
- Continue to be guided by a strategic plan and accordingly set priorities
- Continue with the following workforce strategies
  - Lobby for health care provider courses to be offered within the Region
  - Partner with schools and other sectors
  - Continue student placements
  - Continue and expand student bursaries
- Continue to partner with foundations and auxiliaries
- Implement Rural Hospital Information Systems Project (HISP)
- Continue to review service needs and appropriately align resources to meet those needs
- Encourage the development of and implementation of a regional surgical vision and other regional programs and services.

Report on Performance

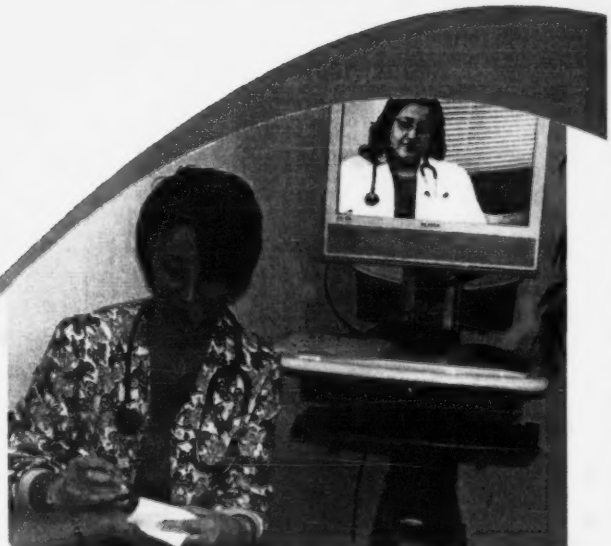
The Regional Health Authority – Central Manitoba Inc. exists so that people in our Region are as healthy as they can be at a reasonable cost to the community.

Central Region's French Language Services Unit awarded Ron Duhamel Award. (March 2007)

Boundary Trails Health Centre MRI Sod Turning (March 2007)



Funding announcement for new Fluoroscopy unit and Surgical equipment at Portage District General Hospital. (February 2007)



Francophone Telehealth services (TéléSanté) launched in four Central communities. (March 2007)

Health Status Report

Individuals in Central Region are AS HEALTHY AS THEY CAN BE

The overall purpose of RHA Central is to provide services and programs to assist "Individuals in Central Region to be as healthy as they can be". To achieve that END, the Board has set targets or priorities by which to measure outcomes. Following are some of those priorities, measures along with the outcomes and achievements for 06/07.

Board END

- Individuals are aware of and demonstrate healthy lifestyle behaviours
- Individuals experience physical wellbeing
  - Individuals are free from preventable illness, death and injury
  - Individuals have healthy weights
- Individuals experience emotional, spiritual & social wellbeing
  - Individuals have healthy relationships
  - Individuals experience healthy family environments
  - Individuals perceive a supportive network within their community
- Individuals have a safe environment
- Individuals have safe physical environments where they work and live
  - Individuals have safe water supplies
  - Individuals breathe healthy air
- Individuals in need of health care experience a timely return to their optimal health
- Individuals receive appropriate care
- Individuals are treated with dignity.

Strategic Priorities

Create an Injury Prevention Strategy and program based on evidence (partnership with stakeholders)

- Farm safety
- Motor vehicle accidents

Some of our results

- Strategizing integration of farm safety messaging
- Evaluating PARTY programs at two regional centres
- Young adult target group identified using IMPACT data.

Create an evidence-based Chronic Disease Strategy, that meets residents' needs (prevention, appropriate care & treatment); reducing the incidence and complications of chronic disease.

Some of our results

- Sessions held with multidisciplinary providers to increase knowledge re. diabetes
- Diabetic Risk Factor & Complication Assessment sessions in MacGregor & Swan Lake/Somerset. Two trainings per year planned
- Collaboration with Fee-for-service (FFS) physicians through Physician Integrated Network (PIN) project for Risk Factor & Complication Assessment (RF&CA) training
    - Healthy Living classes at Portage & Boundary Trails Health Centre
- Evaluation of 'Get Better Together Manitoba' pilot project planned
- Four rural municipalities including Emerson, St. Jean Baptiste, Swan Lake, Somerset, Sanford, Starbuck, Oak Bluff, Brunkild, La Salle and Carman participating in Healthy Living Together
- Three Chronic Disease Prevention Initiative communities (Altona, Winkler and Sandy Bay)
- Youth Survey underway
- Annual Healthy Communities Conference.

Clients receive appropriate mental health care

Some of our results

- Client satisfaction survey completed (83% adults, 86% children & 69% families agreed/strongly to "I like the service I receive here")
- Mental Health Team reviewing and revising range of community services
- Treatment service for focused populations under development.

Decrease number of suicide attempts and completions

Some of our results

- 2004 suicide rate = 9.6/100,000
- 2004 self-inflicted injury rate = 63/100,000
- Chart audit indicates 50% of emergency mental health clients presented with a suicidal presentation
- Provincial work underway on Suicide Prevention Strategy
- Plans to establish a regional Suicide Prevention Committee in 2007-08
- Continue Applied Suicide Intervention Skills Training (ASIST) for staff.

Individuals and communities will access emergency/crisis mental health services in accordance to standards and best practice

Some of our results

- Mental health emergency liaison nurses in place at Boundary Trails Health Centre and Portage District General Hospital
- Client satisfaction surveys completed:
    - 100% satisfaction with care providers
    - Chart audit indicates:
        - minimal to no ER wait time at presentation
        - Appropriate assessment, plans for care and disposition.

Standardize acute care policies and processes throughout the Region for quality, safe care

- Myocardial infarction (MI) care map implemented in 2006 and audit planned in 2008
- Cardiovascular accident (CVA) standard orders implemented in 2006
- Stoke environmental scan completed in 2007
- Regional CVA care map to be developed in 2007-08
- Revision to Acute Coronary Syndrome care map implemented in 2007 following audit of 2006
- Audit of least restraint policy which was implemented in 2006 and planned for 2007
- Review of Emergency Room (ER) utilization completed and indicates volume increases of 5% over last three years (regional sites)
- Same day clinics (Portage, Morden, Winkler) at capacity, based on physician resources
- Standardized client handouts in all ERs
- Review of surgical services provided at four sites reveals:
  - % of surgeries as same day surgeries:
    - 2003/04 = 62%
    - 2004/05 = 63%
    - 2005/06 = 64%
  - In 2004/05 number of patients leaving the Region to have their surgery elsewhere = 3,315
- Regional surgical vision in development
- Developing a standardized Operating Room (OR) Nursing training program.

2006-07 Performance Measures

In the 2005-06 Annual Report, we focused primarily on presenting information from the Canadian Community Health Survey to examine whether there had been any changes in health and lifestyles over the first three cycles of that survey. We also focused on the relationship between health behaviours and chronic diseases. In this report, we focused primarily on health system measures related to "timely returns to optimal health" which will include a focus on appropriateness of care. The other specific topic areas of interest examined in this report are mental health, smoking and injury.

For individuals, the specific performance measures include:

- Self-rated mental health
- Injury hospitalization rates
- Indicators of "Appropriateness"
- 30-day in hospital mortality

Performance Measure SELF-RATED MENTAL HEALTH

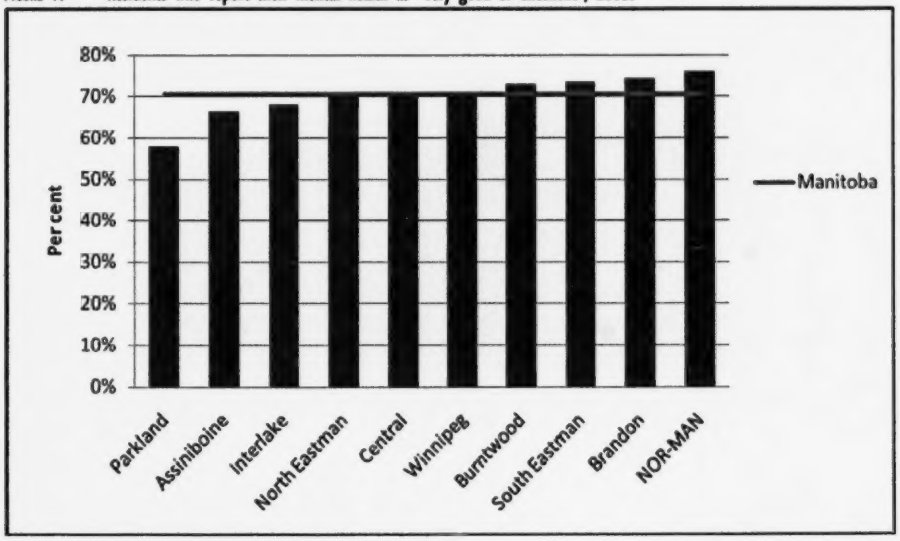
Significance of this Measure

Self-reported mental health provides a general indication of the population suffering from some form of mental disorder, mental or emotional problems, or distress, not necessarily reflected in self-reported (physical) health.

Performance Highlights

As FIGURE 1 shows, in Central Region, just over 70 per cent of residents age 12 and older rate their mental health as "very good" or "excellent". This is the same as the provincial rate. It is interesting to note that people are more likely to rate their mental health in a positive way than their physical health. In the last annual report, we illustrated that just 60.7 per cent of RHA Central residents rated their physical health as "very good" or "excellent". Ratings of "very good" or "excellent" mental health were almost identical among Central Region males (69.5%) and females (71.5%).

FIGURE 1. Residents who report their mental health as "very good or excellent", 2005.



Source: Canadian Community Health Survey, Cycle 3.1 (2005).

Performance Measure INJURY HOSPITALIZATION RATES

Significance of this Measure

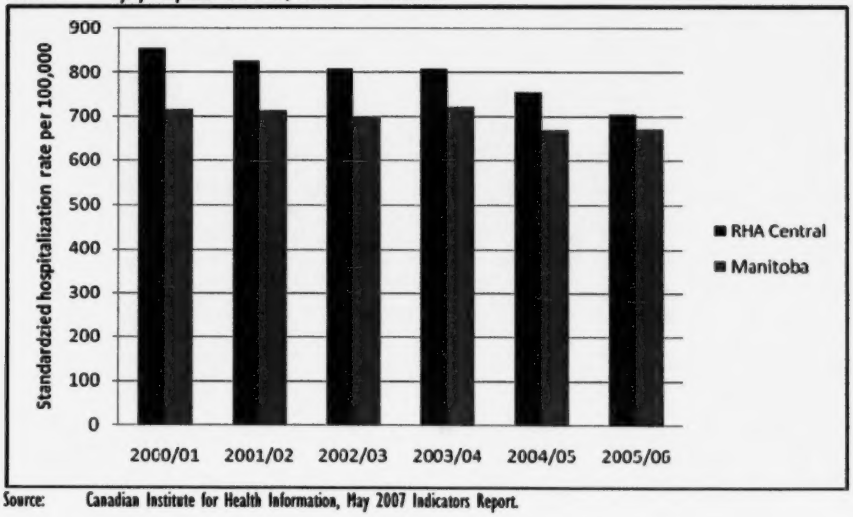
Injury is a serious public health issue having a major impact on the lives of Canadians. According to Health Canada, injury is the leading cause of death of children and young adults and is among the leading causes of hospitalization for children, young adults and seniors. Injury is also a major cause of long and short-term impairment and disability for Canadians.

Injuries are different from other diseases in that they have an immediate onset. The most important factor with respect to injuries is that they are **preventable** through safe and appropriate activities and lifestyle choices.

Performance Highlights

FIGURE 2 shows that (standardized) injury hospitalization rates have consistently been higher among Central Region residents than the provincial average. However, the positive news is that in our Region, injury hospitalization rates have consistently declined between 2000/01 and 2005/06 from 854 per 100,000 to 703 per 100,000. In addition, 2005/06 represents the first year where our regional hospitalization rate is **not** statistically higher than the provincial rate. RHA Central continues to achieve further reductions in the rates of injury as outlined in the strategic priorities pages 27-29.

FIGURE 2. Injury hospitalization rates, 2000/01 to 2005/06.



Source: Canadian Institute for Health Information, May 2007 Indicators Report.

Performance Measure INDICATORS OF "APPROPRIATENESS"

Significance of this Measure

Appropriateness is defined by the Canadian Council of Health Service Accreditation as follows:

Care/service provided is relevant to the clients'/patients' needs and based on established standards.

Indicators of appropriateness can be difficult to interpret. There are some cases where an increase in surgery rates, such as for hip and knee replacement, may indicate availability of services. In other cases, such as with hysterectomy, utilization rates *may* reflect inappropriate use of the procedure. While an increase in rates of hip replacement indicates a benefit for the patient in terms of pain relief and improved quality of life, there is less certainty about whether an increase in hysterectomy rates is beneficial to patients.

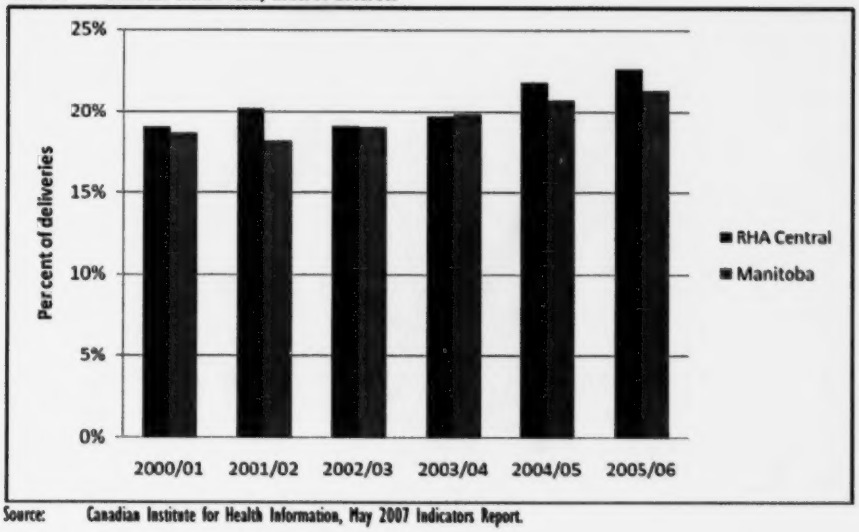
Procedures reviewed in this section include:

- Caesarean section rate (see FIGURE 3)
- Hysterectomy rate (see FIGURE 4)
- Hip replacement (see FIGURE 5)
- Knee replacement (see FIGURE 6).

Performance Highlights

As FIGURE 3 illustrates, caesarean section rates in our Region are very similar to provincial rates. Both regional and provincial rates have shown slight increases over the time period examined. Within our Region, caesarean section rates increased from 19.0 to 22.6 per cent of deliveries in 2005/06.

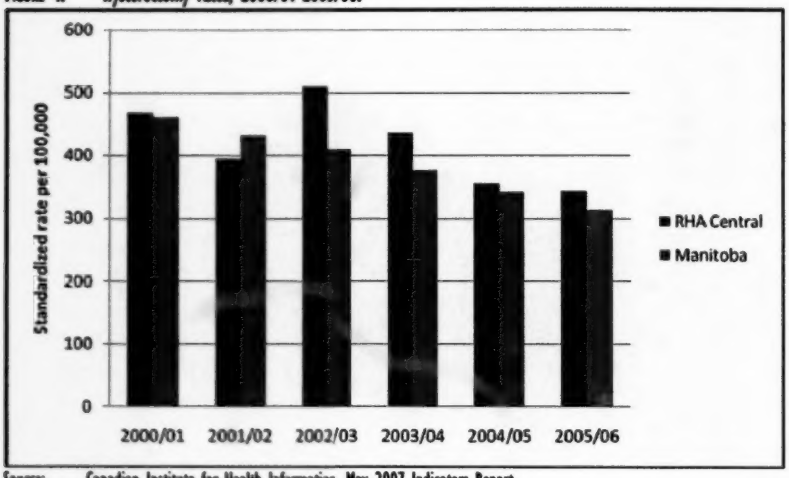
FIGURE 3. Caesarean section rates, 2000/01-2005/06.



Source: Canadian Institute for Health Information, May 2007 Indicators Report.

Hysterectomy rates in both Central Region and the Province overall have been slowly declining between 2000/01 and 2005/06. Although rates in our Region increased in 2002/03, the rates did decline again, and that appears to be continuing. In 2005/06, our hysterectomy rate of 344 per 100,000 was not statistically different from the provincial rate of 314 per 100,000 (see FIGURE 4).

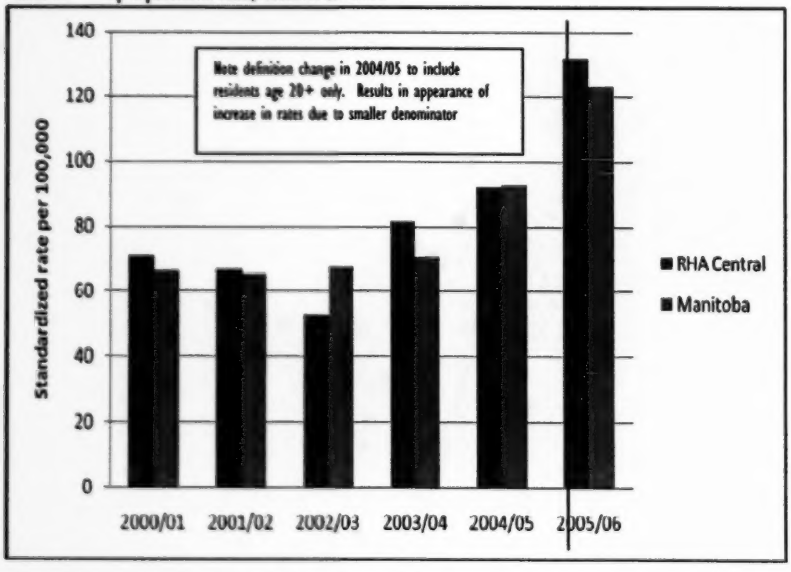
FIGURE 4. Hysterectomy rates, 2000/01-2005/06.



Source: Canadian Institute for Health Information, May 2007 Indicators Report.

Definitions for hip and knee replacement rates changed in 2004/05 to include residents age 20 and older only. This results in a smaller denominator for rate calculation and gives the appearance that rates have increased substantially since 2003/04. FIGURE 5 shows the age standardized rates of hip replacement for Central Region residents and Manitobans overall. In both time periods (before and after the definition change), our regional rates are very similar to provincial rates. It does appear that both regional and provincial rates of hip replacement increased significantly in 2005/06 and we will continue to monitor this data to determine if the trend continues.

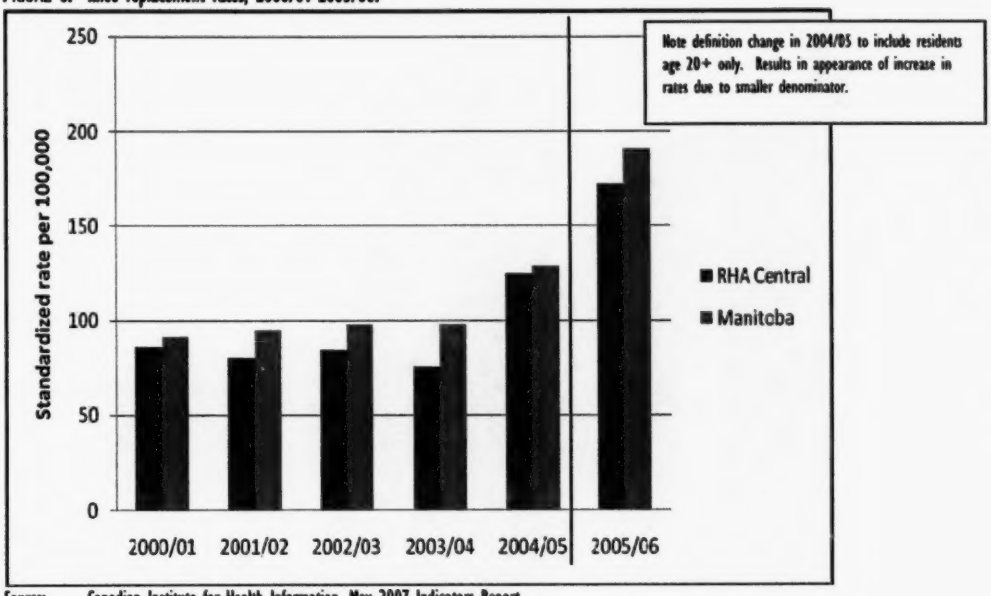
FIGURE 5. Hip replacement rates, 2000/01-2005/06.



Source: Canadian Institute for Health Information, May 2007 Indicators Report.

As FIGURE 6 shows, knee replacement rates have historically been slightly lower for Central Region residents than for Manitobans overall. However, the year 2003/04 was the only year in which the difference in rates was statistically significant. As of 2005/06, the knee replacement rate for Central Region residents age 20 and older was 172.4 per 100,000 which is very similar to the provincial rate of 190.8 per 100,000.

FIGURE 6. Knee replacement rates, 2000/01-2005/06.



Source: Canadian Institute for Health Information, May 2007 Indicators Report.

Performance Measure 30-DAY IN HOSPITAL MORTALITY

Significance of this Measure

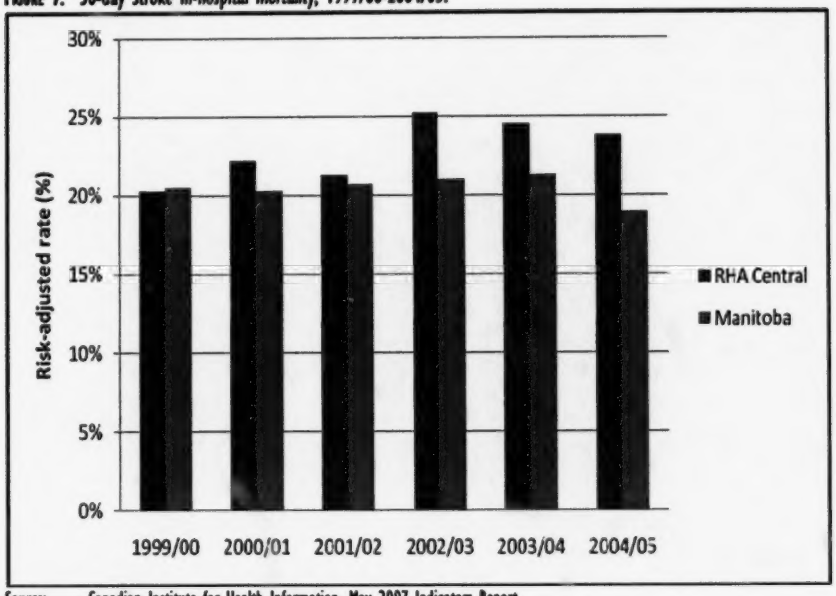
This indicator involves deaths that occurred in hospital 30 days after an individual was admitted with a diagnosis of Stroke or Acute Myocardial Infarction (AMI). According to the Canadian Institute for Health Information (CIHI), adjusted mortality rates (taking into consideration age and sex) following stroke or AMI may reflect the underlying effectiveness of treatment and the quality of care. Please note that the cause of death does not have to be AMI or stroke, the death just must occur within 30 days of being admitted to hospital with one of these conditions.

Performance Highlights

FIGURE 7 shows that in 2004/05, 23.8 per cent of regional residents who were admitted to the hospital with a diagnosis of Stroke died in the hospital within 30 days of that admission. This is a slight increase over time from 20.3 per cent in 1999/00. In both 2002/03 and 2003/04, our regional mortality rates were statistically higher than provincial rates.

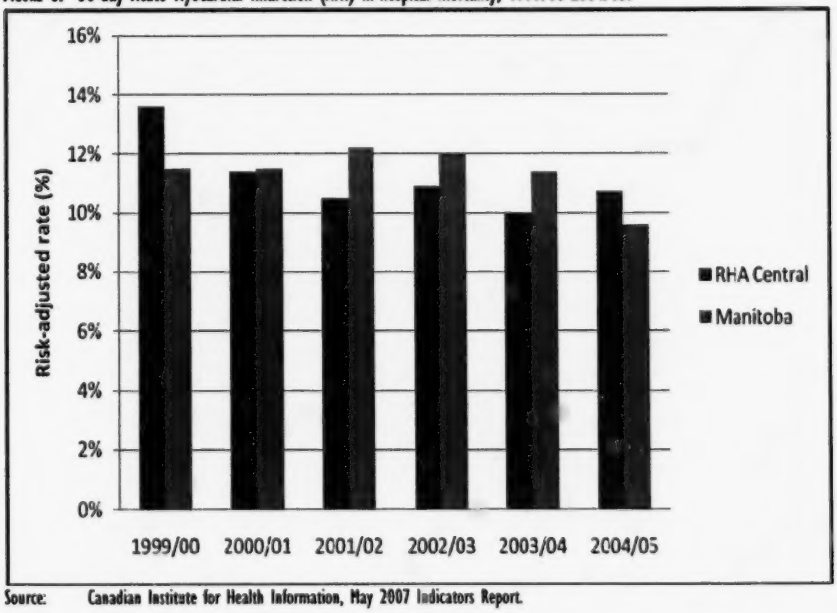
In 2004/05, 10.7 per cent of regional residents who were admitted to hospital with a diagnosis of AMI died in hospital within 30 days of that admission (see FIGURE 8). Rates have declined since 1999/00 when our regional mortality rate was 13.6 per cent and in four out of the six years examined, our rates were lower than the provincial rates.

FIGURE 7. 30-day Stroke in-hospital mortality, 1999/00-2004/05.



Source: Canadian Institute for Health Information, May 2007 Indicators Report.

FIGURE 8. 30-day Acute Myocardial Infarction (AMI) in-hospital mortality, 1999/00-2004/05.



Source: Canadian Institute for Health Information, May 2007 Indicators Report.

Children are As HEALTHY AS THEY CAN BE

The overall purpose of RHA Central is to provide services and programs to assist "children in Central Region to be as healthy as they can be". To achieve that END, the Board has set targets or priorities by which to measure outcomes. Following are some of those priorities, measures along with the outcomes and achievements for 06/07.

Board END

- Children have healthy growth and development
  - Children do not die in infancy
  - Children remain free from preventable death or injury
  - Children are protected from communicable diseases
  - Children are physically active
  - Children practice healthy eating
- Children are born without and remain free from the harmful effects of tobacco, alcohol, drugs and solvents
- Children have responsible and effective guardianship
- Children have high levels of self-esteem
- Children make age-appropriate and culturally appropriate lifestyle choices
- Children have access to the highest educational attainment
- Children feel safe in their environment.

Strategic Priorities

Identify and treat children with developmental delays
Support parents with information

Some of our results

- Develop and implement pre-school wellness fairs (collecting and evaluating stats)
- Now using a common referral form with a Central Intake for Therapy referrals supported by a database for all therapy referrals (except school Speech Language Pathology)
- Intersectoral working group with school divisions, Family Services & Housing (FS&H), RHA Central, Healthy Child Coalition, Rehab Centre for Children & Society for Manitobans with Disabilities (SMD)
- Regional Preschool Wellness Fair Collaborative Planning Guidelines developed (bilingual)
- 2008-09 will establish database with school divisions for children with developmental delays in kindergarten
- Transition planning for preschool and school age children under development
- Children's Therapy Initiative will develop evaluation of Child Outcomes (parent/service provider feedback)
- Planning for Regional Implementation of I HEAR Manitoba Program (Infant Hearing Early Assessment & Referral) to begin.

Work with partners to develop and support the overall wellbeing of students and their communities

Some of our results

- Intersectoral groups established
- Preschool wellness fair planning guidelines
- Teen health clinic proposal
- Children's Therapy Initiative underway
- Regional Youth Survey ('07)
- RHA Board '07 workshop with school divisions (Feb).

2006-07 Performance Measures

- Immunization
- Exposure to Second-Hand Smoke
- Age of smoking initiation
- Teen Pregnancy and Births
- Healthy Birth weights
- Readiness to learn

Performance Measure IMMUNIZATION

Significance of this Measure

Vaccines are one of the most important components of child health programs. Vaccines can prevent disability and death and control the spread of infectious diseases within communities. As the result of immunization programs, vaccine-preventable diseases have gone from being the leading causes of death in the early 1900s to causing less than five per cent of all deaths in Canada[1].

Performance Highlights

TABLE 1 compares our Region's immunization coverage rates to the Province by age over a four-year period. The vaccines reviewed were the established immunizations (DTaPP-HIB, MMR and HBV). The newer vaccines (Varicella, Prevnar and Menjugate C) are not included at this time in the analysis.

TABLE 1. Percentage complete for age by age group and year, 2002-2005.

	Age Group	2002	2003	2004	2005
RHA CENTRAL	1 year old	85.3 %	81.3%	75.9%	74.2%
	2 years old	75.3%	73.2%	64.9%	61.7%
	7 years old	75.0%	73.2%	71.4%	70.7%
	11 years old	58.0%	61.7%	59.4%	62.0%
	17 years old	63.7%	63.1%	65.4%	65.5%
MANITOBA	1 year old	83.5%	85.2%	79.7%	79.0%
	2 years old	72.5%	72.9%	67.2%	65.5%
	7 years old	69.3%	69.3%	64.6%	63.4%
	11 years old	54.1%	57.3%	57.4%	58.1%
	17 years old	48.6%	48.6%	51.7%	53.5%

Source: Manitoba Immunization Monitoring System and Dr. S. Buchan, MOH RHA Central.

In our youngest age groups, Central has seen a 10 per cent decline in immunization completeness between 2002 and 2005. Our immunization rates are now slightly lower than the provincial average for one and two year olds. In looking at the district level, there has also been decline over time but the rate of decline differs in each area. The lower numbers in our two largest sites (Portage and Morden/Winkler) bring our total average down even though several of the sites are the same or higher than provincial average (see TABLE 2).

TABLE 2. Percentage complete for age by district, 2005.

	1 year olds	2 year olds
Cartier and area	100%	79.4%
Portage and area	66.0%	56.7%
Seven Regions (Gladstone)	49.5%	38.7%
Carman/St Claude area	82.8%	73.2%
Swan Lake/Notre Dame	84.8%	72.1%
Louise/Pembina	65.3%	76.2%
Morden/Winkler	74.0%	56.7%
Altona and area	79.1%	64.9%
Red River area	88.1%	71.9%
Manitoba average	**79.0%**	**65.5%**

Source: Manitoba Immunization Monitoring System and Dr. S. Buchan, MOH RHA Central.

In 2006, Manitoba Health instituted a mail-out at 13 and 20 months of age for children who are not up to date to help remind parents of the importance of vaccination. This type of initiative has helped to improve vaccination rates in adults and the Region will continue to monitor whether it will help improve rates in children.

Central Region held a workshop in the fall of 2006 with the Healthy Living Team, Child and Adolescent and Women's Teams along with the Communicable Disease Control Working group. This resulted in a 10-point strategy that our Region will work on to help improve vaccinations rates. Physician practice of informing parents of the value of immunization during clinic visits is known to improve participation in the publicly funding programs. Through the developmental work of the Physician Integrated Network (PIN), physicians will be further encouraged to continue to inform parents about the importance of immunizations.

Performance Measure EXPOSURE TO SECOND-HAND SMOKE

Significance of this Measure

Although Second-Hand Smoke (SHS) is dangerous to everyone, fetuses, infants and children are at most risk. This is because SHS can damage developing organs, such as the lungs and brain[ii].

Some details about the impacts of SHS on children[iii].....

The fetus and newborn: Maternal, fetal, and placental blood flow change when pregnant women smoke, although the long-term health effects of these changes are not known. Some studies suggest that smoking during pregnancy causes birth defects such as cleft lip or palate. Smoking mothers produce less milk, and their babies can have a lower birth weight. Maternal smoking also is associated with death from Sudden Infant Death Syndrome.

Children's lungs and respiratory tracts: Exposure to SHS decreases lung efficiency and impairs lung function in children of all ages. It increases both the frequency and severity of childhood asthma. Second-hand smoke can aggravate sinusitis, rhinitis, cystic fibrosis, and chronic respiratory problems such as cough and postnasal drip. It also increases the number of children's colds and sore throats. In children under two years of age, SHS exposure increases the likelihood of bronchitis and pneumonia. Children of parents who smoke half a pack a day or more are at nearly double the risk of hospitalization for a respiratory illness.

The Ears: Exposure to SHS increases both the number of ear infections a child will experience, and the duration of the illness. Inhaled smoke irritates the eustachian tube, which connects the back of the nose with the middle ear. This causes swelling and obstruction which interferes with pressure equalization in the middle ear, leading to pain, fluid and infection. Ear infections are the most common cause of children's hearing loss.

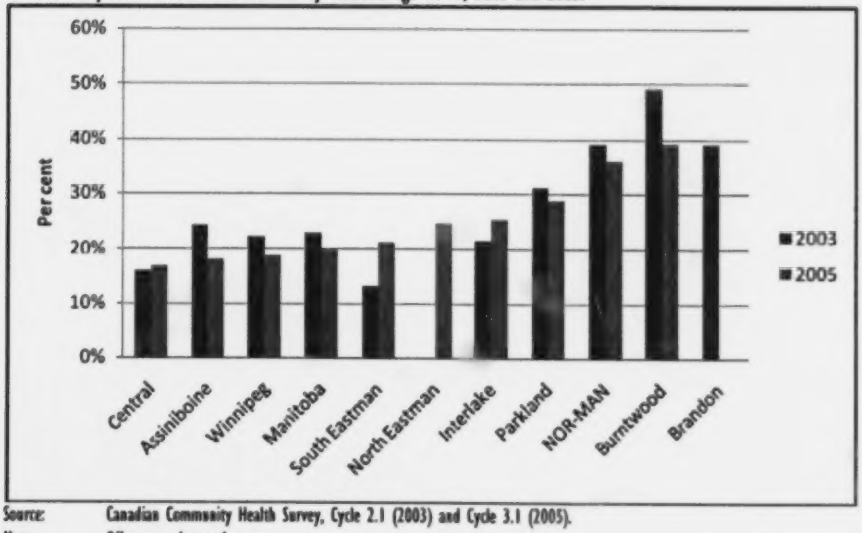
The Brain: Children of mothers who smoked during pregnancy are more likely to suffer behavioral problems such as hyperactivity than children of non-smoking mothers.

Performance Highlights

According to Families First screening data collected between 2003 and June 2007, 13.9 per cent of pregnant women in Central Region smoked during pregnancy. This is much lower than the provincial rate of 20.6 per cent; however it is still too high. It is also important to note that this screening data is for women living off-reserve only. Because we know that smoking rates are high for those living on reserve, we must assume that true smoking rates during pregnancy are actually higher than 13.9 per cent.

Another source of information about exposure to second-hand smoke (SHS) is the Canadian Community Health Survey. Again, the caution is that these data are for off-reserve residents only. However, **FIGURE 9** shows that 16.8 per cent of Central Region youth (age 12-19) were exposed to second-hand smoke in the home in 2005. This is similar to the rate of 15.9 per cent reported in the 2003 survey. Both rates are lower than the provincial rates of 22.9 per cent in 2003 and 20.0 per cent in 2005. It is important to note that exposure to SHS is much higher among youth than among adults. For example, in 2005, just 7.2 per cent of residents reported being exposed to SHS in the home. However, again when we look at youth only, this rate increases to 16.8 per cent. This may be reflective of the lack of choice children and youth have in their homes – while adults can chose whether or not to live with an individual who smokes and whether to allow smoking in the home, this is not the case for children.

FIGURE 9. Exposure to Second-Hand Smoke by residents age 12-19, 2003 and 2005.



Source: Canadian Community Health Survey, Cycle 2.1 (2003) and Cycle 3.1 (2005).
Note: Off-reserve data only.
Note 2: Definitions changed after Cycle 1.1 so data are not comparable to 2000/01 data.
Note 3: 2003 North Eastman and 2005 data suppressed by Statistics Canada.

Performance Measure AGE OF SMOKING INITIATION

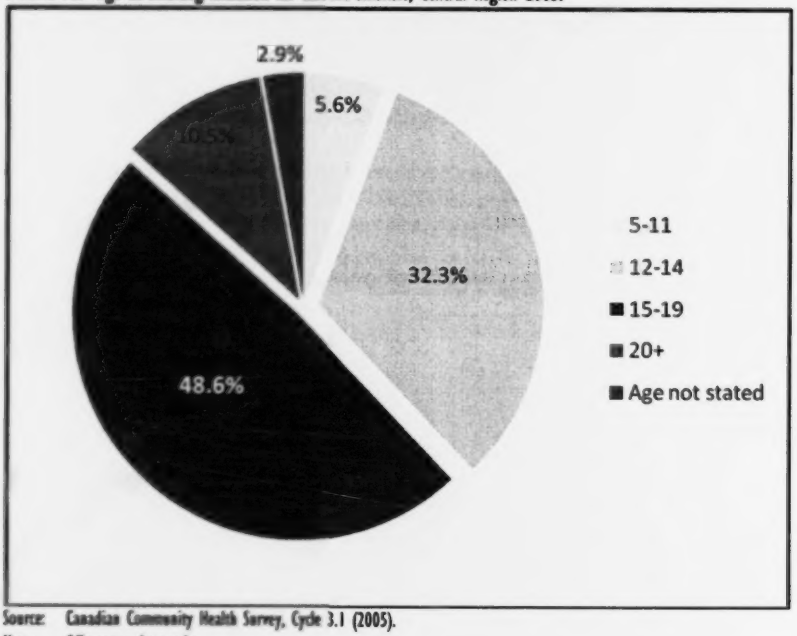
Significance of this Measure

Lifetime smoking and other tobacco use almost always begins by the time that person has left high school[iv]. Experimentation with cigarettes can often develop into regular smoking which can lead to a strong nicotine addition. This frequently occurs by the time the person has reached the age of 18. Delaying the age at which people begin smoking can reduce the risk that they become regular or daily smokers and increase their chances of successfully quitting if they do begin regular smoking.

Performance Highlights

In 2005, almost one-half of current smokers reported that they had started smoking between the ages of 15 and 19. One-third of current smokers started smoking between the ages of 12 and 14. The proportion of smokers who started smoking between just 12 and 14 is more than three times that of people who started smoking after the age of 20. Only one in ten current smokers started smoking at age 20 or later (see FIGURE 10). These data confirm that we must continue to focus our prevention efforts on children – particularly those in grades 6 to 12.

FIGURE 10. Age at smoking initiation for current smokers, Central Region 2005.



Source: Canadian Community Health Survey, Cycle 3.1 (2005).
Note: Off-reserve data only.

Performance Measure TEEN PREGNANCY AND BIRTHS

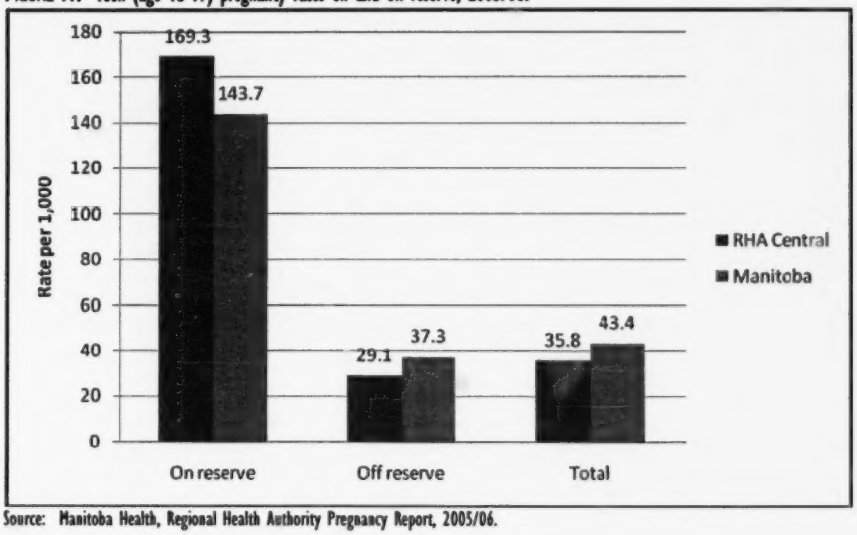
Significance of this Measure

Teen pregnancy is considered a major public health issue in many countries. This is because research has shown that teenage mothers are less likely to complete their education and are more likely to have limited career and economic opportunities[v]. In addition, their babies are at increased risk of preterm birth, low birth weight and death during infancy.[vi]

Performance Highlights

In 2005/06 the pregnancy rates among Central Region residents age 15 to 19 was 35.8 per 1,000. This is lower than the provincial rate of 43.4 per 1,000. FIGURE 11 shows that the pregnancy rate for teens living on reserve is much higher (169.3 per 1,000) than for teens living off reserve (29.1 per 1,000). In fact our on-reserve teen pregnancy rate is higher than the provincial average of 143.7 per 1,000.

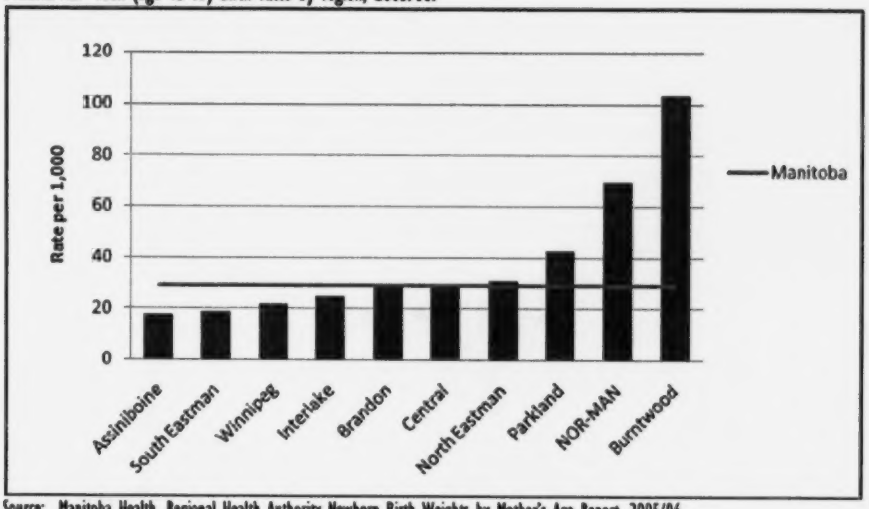
FIGURE 11. Teen (age 15-19) pregnancy rates on and off reserve, 2005/06.



Source: Manitoba Health, Regional Health Authority Pregnancy Report, 2005/06.

FIGURE 12 shows birth rates for teens (age 15-19) in 2005/06 by region. The teen birth rate in Central Region of 29.3 births per 1,000 is the same as the provincial rate. However, this does represent an increase from 2000/01 where our teen birth rate was 23.1 births per 1,000.

FIGURE 12. Teen (age 15-19) birth rates by region, 2005/06.



Source: Manitoba Health, Regional Health Authority Newborn Birth Weights by Mother's Age Report, 2005/06.

Performance Measure HEALTHY BIRTHWEIGHTS

Significance of this Measure

In this section we will look at two categories of birth weights that are considered to be unhealthy. The first is Low Birth Weight (LBW) which includes all infants born weighing less than 2,500 grams. The second is High Birth Weight (HBW) and this includes all infants born weighing more than 4,000 grams.

TABLE 3 illustrates two broad categories of risk factors for low birth weight infants. The most important thing to note is that many, if not all, of these risk factors are modifiable which means that we can have an impact on our LBW rates.

TABLE 3. Risk factors for low birth weight (LBW) infants.

SOCIAL RISK FACTORS	PERSONAL
• Poverty • Single parent • Teenage parent • Little or no prenatal care • Living with a violent partner • Generally stressful life • Workplace conditions • Type and amount of work	• Smoking • Alcohol and other drug use • Poor nutrition before and during pregnancy • Limited stress-relief strategies

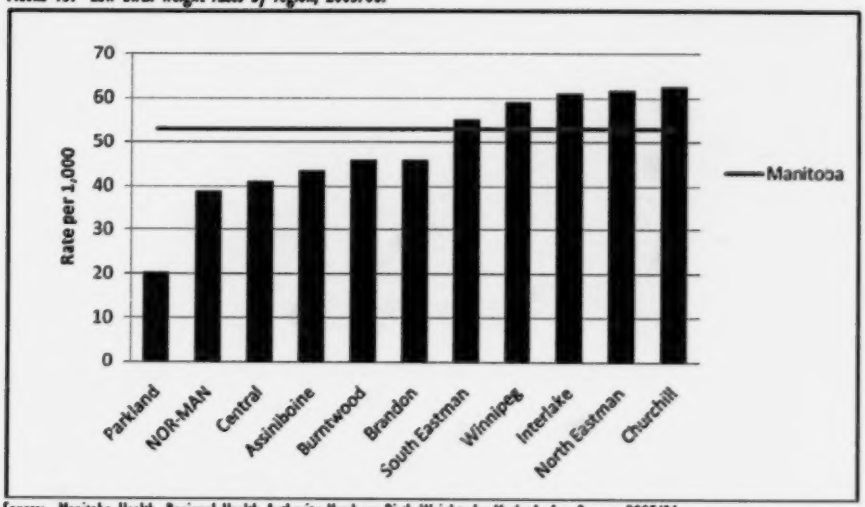
Pregnant women who are diagnosed with gestational diabetes are at higher risk for delivery of a high birth weight (HBW) infant. Research has shown an increased risk of developing Type 1 Diabetes for HBW infants[vii]. In addition, Health Canada advises that HBW infants are at greater risk of infant mortality than are normal weight infants.

Performance Highlights

FIGURE 13 shows LBW rates by region for 2005/06. This graph illustrates that the rate of LBW infants in Central Region is lower than the provincial average (41.0 per 1,000 births compared to 52.9 per 1,000 in Manitoba). Our regional rate also represents a decrease from 1996/97 when our rate was 45.3 per 1,000 births, while at the same time the provincial rate increased slightly from 50.5 per 1,000 in 1996/97.

Within our Region in 2005/06, the rate of LBW infants was higher for women living on reserve at 78.9 per 1,000 births compared to 37.6 per 1,000 births for women living off-reserve.

FIGURE 13. Low birth weight rates by region, 2005/06.

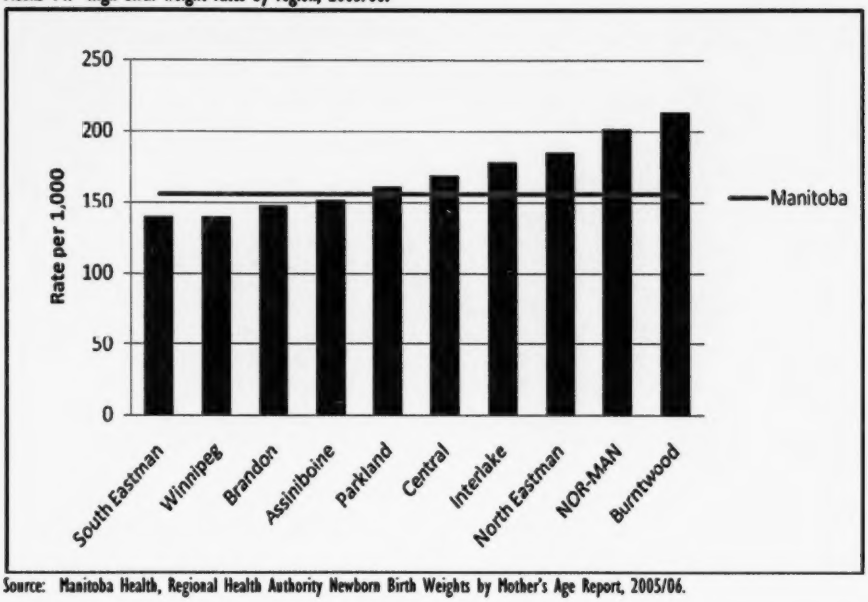


Source: Manitoba Health, Regional Health Authority Newborn Birth Weights by Mother's Age Report, 2005/06.

FIGURE 14 shows HBW rates by region for 2005/06. This graph illustrates that the rate of HBW infants in Central Region is slightly higher than the provincial average (168.2 per 1,000 births compared to 155.6 per 1,000 in Manitoba). Our regional rate also represents a decrease from 2000/01 when our HBW rate was 181.2 per 1,000 births.

Within our Region in 2005/06, the rate of HBW infants was lower for women living on reserve at 122.8 per 1,000 births compared to 172.3 per 1,000 births for women living off-reserve.

Figure 14. High birth weight rates by region, 2005/06.



Source: Manitoba Health, Regional Health Authority Newborn Birth Weights by Mother's Age Report, 2005/06.

Performance Measure READINESS TO LEARN

Significance of this Measure

There is growing evidence that early childhood experiences have significant long-term effects. What happens to children when they are very young shapes their health and wellbeing, including their capacity for life-long learning and overall success.

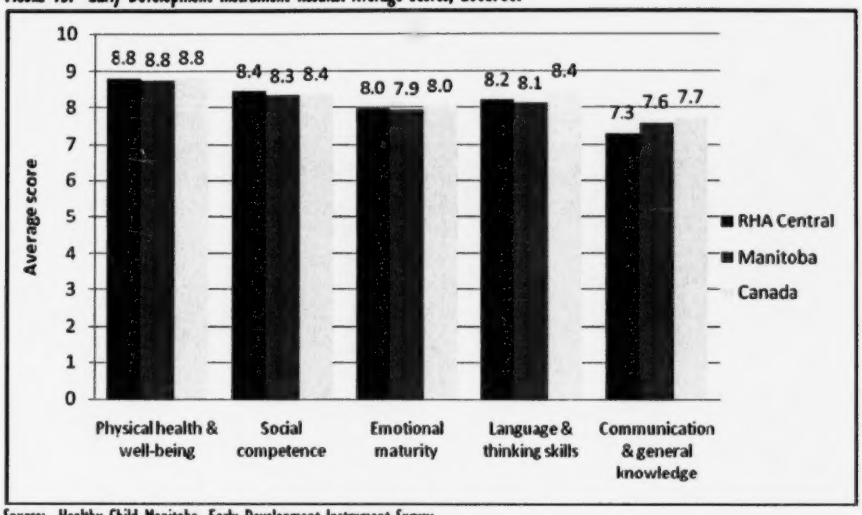
"Readiness to Learn" is a measure of many aspects of a child's development at age 5, a key developmental transition for most children. Being "ready to learn" includes: physical wellbeing and age-appropriate physical development (e.g., fine and gross motor skills); emotional health, including an ability to adapt to new experiences; age-appropriate social knowledge; language skills; and, general knowledge[viii]. In Manitoba, Readiness to Learn is measured by the kindergarten teacher using the Early Development Instrument (EDI).

This measurement is a powerful predictor of a child's future wellbeing, including development of a child's sense of self-respect and concern for others, literacy and overall academic performance, propensity towards life-long learning, health status as an adult as well as anti-social and risk-taking behaviours[ix].

Performance Highlights

FIGURE 15 shows that on each of the five measures of Readiness to Learn, students in our Region scored very similarly to students in Manitoba and Canada.

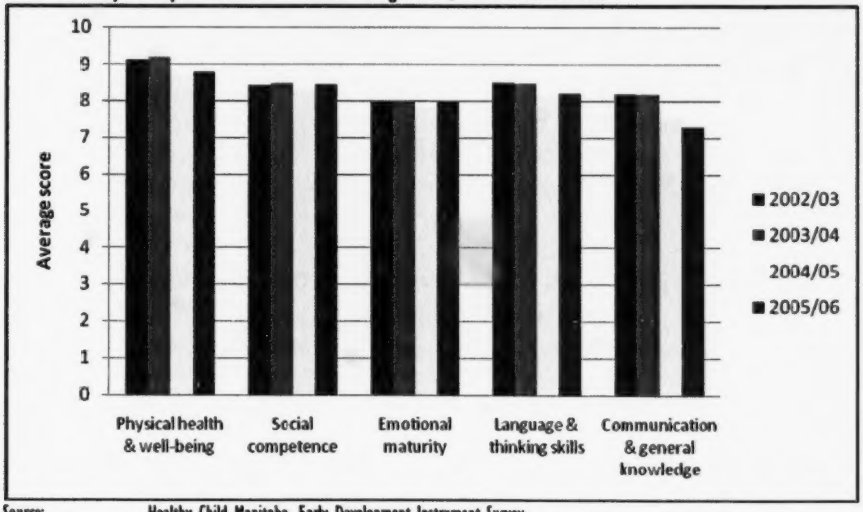
FIGURE 15. Early Development Instrument Results: Average Scores, 2005/06.



Source: Healthy Child Manitoba, Early Development Instrument Survey.

FIGURE 16 shows changes over time in average EDI scores for Central Region students. There has been a slight decrease in scores for the area of "Communication and General Knowledge" but for the most part, scores have remained relatively stable.

FIGURE 16. Early Development Instrument Results: Average Scores, 2002/03 to 2005/06.

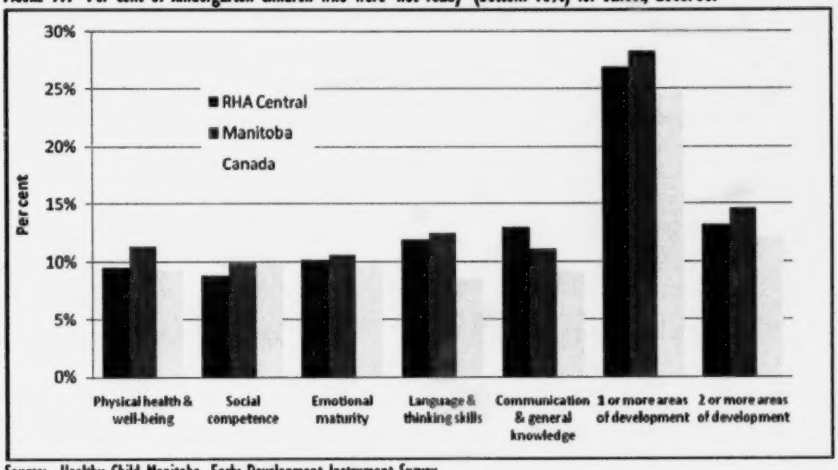


Source: Healthy Child Manitoba, Early Development Instrument Survey.

NOTE: Due to changes in the 2004/05 EDI questionnaire, average vales for 2002/03 and 2003/04 have been adjusted to be comparable to 2004/05 values.

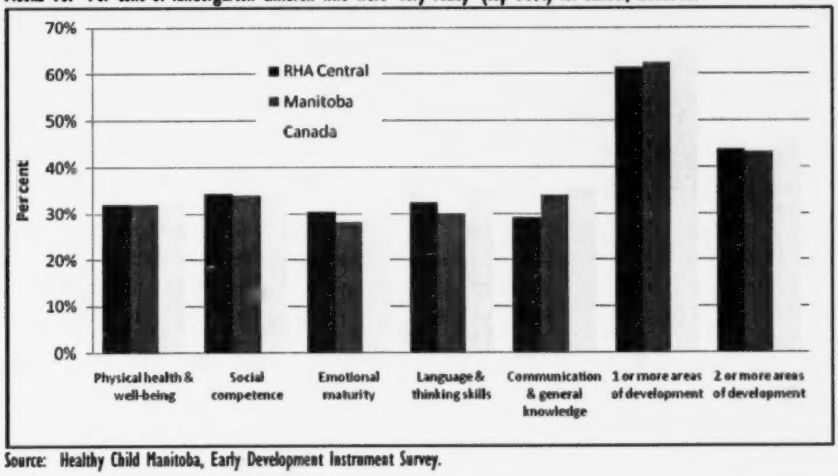
Overall, in 2005/06, 27.0 per cent of Central Region children in kindergarten were not ready to learn in at least one of the five measures. This is similar to the provincial average of 28.3 per cent of children but higher than the Canadian average (see FIGURE 17). On the positive end of the scale, 61.5 per cent of our children are "very ready" to learn in at least one area when they start kindergarten which is similar to the provincial rate of 62.4 percent (see FIGURE 18).

FIGURE 17. Per cent of kindergarten children who were 'not ready' (bottom 10%) for school, 2005/06.



Source: Healthy Child Manitoba, Early Development Instrument Survey.

FIGURE 18. Per cent of kindergarten children who were 'very ready' (top 30%) for school, 2005/06.



Source: Healthy Child Manitoba, Early Development Instrument Survey.

Aboriginals, including First Nations, Métis and Inuit are As HEALTHY AS THEY CAN BE

The overall purpose of RHA Central is to provide services and programs to assist "aboriginals in Central Region to be as healthy as they can be". To achieve that END, the Board has set targets or priorities by which to measure outcomes. Following are some of those priorities, measures along with the outcomes and achievements for 06/07.

Board END

- Aboriginals live at least as long as other people in Central Region
  - Children and adolescents practice healthy lifestyle behaviours
  - Aboriginals will not die from complications of diabetes.
- Aboriginals have hope and pride and dignity
  - Aboriginals receive psychosocial support in situations that diminish their hope, pride and dignity.
- Aboriginals receive the services they need despite jurisdictional barriers
  - Aboriginals live in a healthy environment.
- Aboriginals receive culturally appropriate health care.

Strategic Priorities

Create a culturally competent organization providing culturally appropriate services to all clients, particularly aboriginal clients.

Some of our results

- Aboriginal Workforce Initiative introduced in 2005-06. Staff offered the opportunity to self-identify
  - Stats as of 2006-07: 48/2,633 = 1.8%
- Cultural education sessions offered at Regional General Orientation
- other sessions for current staff
  - # of sessions has increased from 5 in 2005-06 to 47 in 2006-07
  - reached 100 staff in 2005-06
  - 690/2,633 receiving cultural awareness education in 2006-07
- Aboriginal representation at RHA Central Board Table
- Regional Spiritual Care Advisory Committee active
- Ojibway language lessons initiated by social worker at Portage District General Hospital
- Exploring Aboriginal liaison worker positions to facilitate cross-cultural relationship building
- Language translation (Ojibway) in process
- "Its Safe to Ask" patient safety information
- Mental health assessment tool
- Aboriginal Liaison Committee Portage Hospital
- Collaborating with Roseau River First Nation (Ginew Health Centre) electronic medical record proposal
- Swan Lake First Nation, Sandy Bay First Nation, Roseau River First Nation participating in Risk Factor Complications Assessment (RFCA) training related to Diabetes
- Memorandum of Understanding in process with Aboriginal Friendship Centre Portage to support diabetes prevention & healthy living
- Participation in Dakota Tipi Health Fair per request March '07

- Portage Friendship Centre facilitated cultural awareness workshops at Portage District General Hospital
- Continued Partnership with Sandy Bay First Nation for Chronic Disease Prevention Initiative (CDPI)
- RHA Board will be requesting a visit to Sandy Bay in 2007-08 as part of its ownership linkage
- Aboriginal recruitment and retention report completed Fall 2006
- Ongoing discussions with Aboriginal and Northern Affairs to look at ways to partner further in recruitment and retention of aboriginal employees throughout the organization
- Cultural competency component in Regional General Orientation for all new staff and as a core competency in the revised Professional Appraisal Program
- Cultural competency and Aboriginal cultural awareness workshops are ongoing throughout the Region.

2006-07 Performance Measures

- Acute Care Hospitalization
- Diabetes

Performance Measure ACUTE CARE HOSPITALIZATION

Significance of this Measure

Health care accessibility is one of the principles of the Canada Health Act. This means that reasonable access by insured persons to medically necessary hospital and physician services must be unimpeded by financial or other barriers. Accessibility can also be thought of more broadly, sometimes there are barriers beyond those identified by the Act that can impact the ability of some cultural groups to access health services. Aboriginal people have identified that access to health services is an issue that must be addressed.

There has been a perception that it is difficult for First Nation residents (especially those living on reserve) to access health services. It is important to also review utilization data to determine if there appears to be a lower than expected rate of hospital service utilization among this group. This measure is also important to review so that we can determine where our Aboriginal population is receiving health care and work together on the development of culturally appropriate services both at the community and acute care level.

Performance Highlights

Within Central Region, the standardized hospitalization rate among First Nation people living on reserve was 367.9 per 1,000 residents in 2005/06. This is 3.3 times the standardized rate of 112.1 per 1,000 for all other regional residents. This is partly due to the higher rates of some diseases (such as diabetes) that can require hospitalization but it is also due to the higher birth rates (most of which take place in hospital) among First Nation residents.

In 2005/06, when First Nation people (living on reserve) were hospitalized, three-quarters of the hospitalizations (74.5%) were accommodated in the Region (compared to 70.3% of all other residents) – that is they were able to receive their care in the Region and closer to home. The majority of hospitalizations outside of Central Region occur in Winnipeg – 20.7 per cent of First Nation hospitalizations compared to 24.0 per cent of hospitalizations for other Central Region residents.

Performance Measure DIABETES

Significance of this Measure

Diabetes is a serious and growing public health problem in Manitoba, particularly in Aboriginal populations. Diabetes is a serious, chronic, systemic disease characterized by the body's inability to sufficiently produce and/or use insulin – a hormone produced by the pancreas that assists with the conversion of glucose (sugar) into energy. Without insulin, blood sugar levels rise to dangerous levels, interfering with the proper nourishment of body cells.

The burden of illness associated with diabetes is increased by the fact that people with diabetes are at greater risk of other diseases than people without diabetes. This risk is strongly related to high blood sugar and the duration of diabetes. Chronic high levels of blood glucose can lead to heart disease and stroke, blindness, kidney disease, amputations, nerve disease, amputations, and other complications.

A recent report prepared by Manitoba Health illustrated diabetes rates for residents of Manitoba. Some of the key findings were:

- The number of treaty status[2] persons living with diabetes has more than tripled between 1989 and 2006. The number of male treaty status persons living with diabetes has almost quadrupled in this time.
- Diabetes prevalence is highest in treaty status females at 19.9 per cent (2006). This is more than four times the prevalence rate of 4.6 per cent in non-treaty females.
- For male treaty status persons, the diabetes prevalence rate was about three times higher than in non-treaty Manitoba males.
- 53 per cent of treaty status Manitobans between the ages of 60 and 79 were living with diabetes in 2006.
- Between 1989 and 2006, treaty status Manitobans were about three times as likely to be diagnosed with diabetes in any year compared to non-treaty status Manitobans.

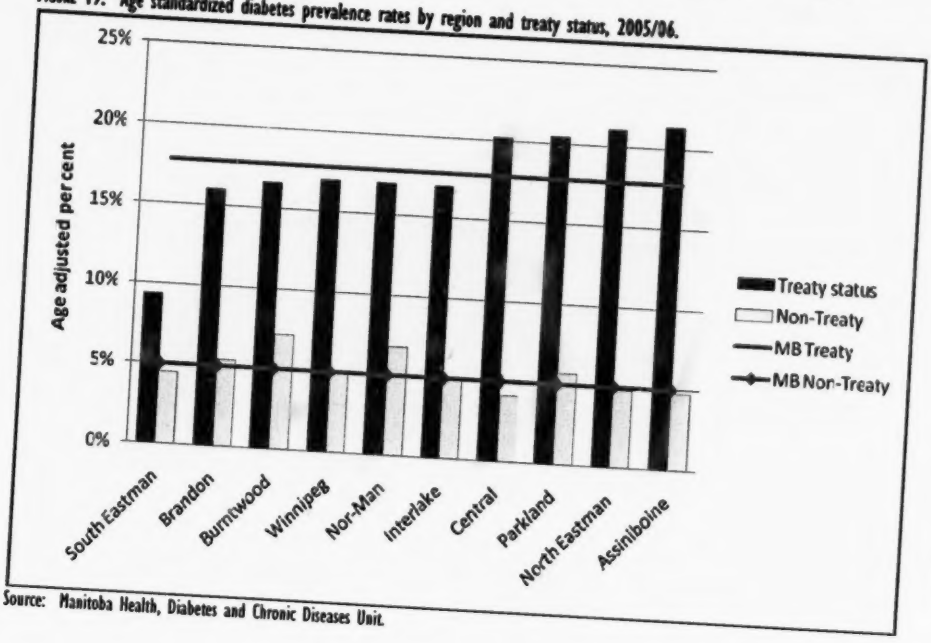
Performance Highlights

In 2005/06, 5,299 residents of Central Region were living with diabetes. Treaty status residents of our Region accounted for 625 or 11.8 per cent of these cases. It is important to note that in 2006, only 3.7 per cent of RHA Central residents were identified as First Nation through the health registry. This means that the proportion of residents with diabetes who are First Nation is very much over-represented in comparison to their proportion of our population.

[2] The term Treaty Status was used in the context of this report to describe those identified as registered Indian in the Manitoba Health Insurance Registry. Manitoba Health undercounts Registered First Nations living in Manitoba (77,371 in 2004 vs. 123,378 reported by Indian and Northern Affairs Canada for the same year) because not all registered Indians report their status when applying for health coverage.

FIGURE 19 shows the diabetes prevalence rates for 2005/06 by both gender and treaty status. This graph shows that just under 5 per cent of non-treaty status residents were living with diabetes in 2005/06 compared to 20 per cent of treaty status Central Region residents. This graph also shows that while our off-reserve diabetes prevalence rates are lower than the provincial average, our on-reserve rates are significantly higher than the on-reserve provincial rates.

FIGURE 19. Age standardized diabetes prevalence rates by region and treaty status, 2005/06.



Source: Manitoba Health, Diabetes and Chronic Diseases Unit.

Women are As HEALTHY AS THEY CAN BE

The overall purpose of RHA Central is to provide services and programs to assist "women in Central Region to be as healthy as they can be". To achieve that END, the Board has set targets or priorities by which to measure outcomes. Following are some of those priorities, measures along with the outcomes and achievements for 06/07.

Board END

- Women have safe living and working conditions
  - Women are free from violence
  - Women have sufficient financial resources
- Women have good reproductive health
- Women are supported in their care-giving role.

Strategic Priorities

Develop a women's centered health framework in collaboration with intersectoral partners

Some of our results

- Researched evidence-based frameworks
- Selected (with adaptations) the Vancouver/Richmond women's centered health framework
- Will consult with external stakeholders to implement framework.

Develop a comprehensive healthy women's program

Some of our results

- Carman, Emerson, Swan Lake, Portage and Altona held wellness events
- Designed and produced a Women's Health display to be utilized throughout the Region (used 6 times)
- Health promotion educational sessions offered in four communities, one a regional event
- 6 physician clinics participated in the "Provincial Pap Test Day" with CancerCare MB
- 3-year participation rates ('03,'04) for Pap tests and colposcopy (compared to the provincial average):
  - 18-19 yr 36% compared to 46.4%
  - 20-29 yr 54.6% compared to 57.3
  - 30-39 yr 54.2% compared to 55.2%
  - 40-49 yr 49.7% compared to 53.2%
  - 50-59 yr 47.9% compared to 50.1%
  - 60-69 yr 40.2% compared to 45.1%
  - All 49.6% compared to 52.7%
- Mammography rates = 59% of total eligible.

Develop and implement an infant nutrition strategy

Some of our results

- Implemented breastfeeding practice guidelines throughout all community programs and obstetrical units
- Monitoring of breastfeeding initiation rates (Breastfeeding =74%; Post Breastfeeding =84%)
- Implementation of the LATCH-R tool staff education (a breast feeding technique) (20% complete) and audit underway.

2006-07 Performance Measures

- Cervical cancer screening
- Breast cancer screening

Performance Measure CERVICAL CANCER SCREENING

Significance of this Measure

Regular pap smears can prevent or detect early cell changes that can be the precursor to cervical cancer. Risk factors associated with cervical cancer include early age of sexual intercourse, sexually transmitted infection, low socio-economic status and smoking. Cervical cancer should be dramatically reduced in Manitoba with the introduction of a vaccine for girls and young women.

Research demonstrates that there are groups of women who tend to participate less in screening, including cervical cancer screening. These women are considered hard to reach or under-served because there are particular obstacles that keep them from accessing this test.

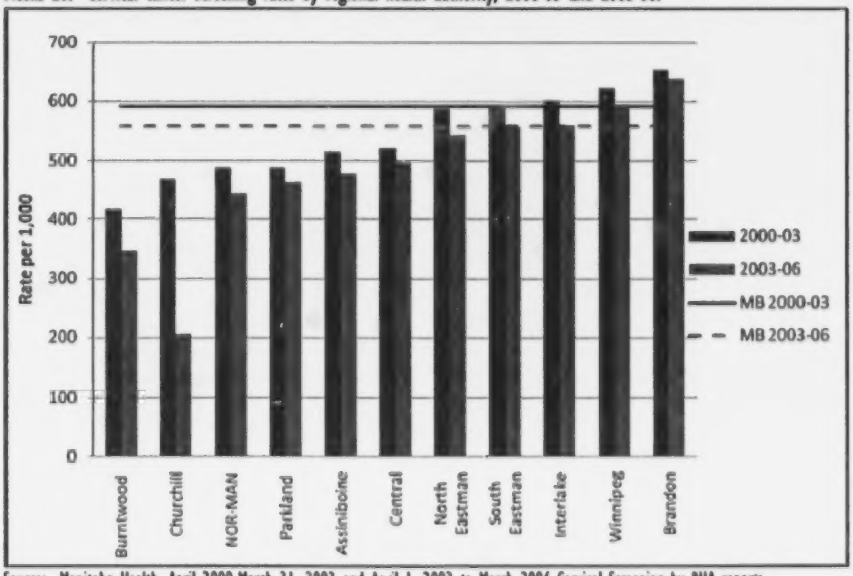
These women include:

- Older women
- Immigrant women
- Aboriginal women
- Women living in poverty
- Rural women
- Women with less education

Performance Highlights

FIGURE 20 shows cervical cancer screening rates for two time periods: April 1, 2000 to March 31, 2003 and April 1, 2003 to March 31, 2006. Screening rates in Central Region decreased very slightly between the two time periods from 520.5 per 1,000 women in the first time period to 497.7 in the second. Provincial rates also decreased slightly in this period from 591.4 to 556.9 per 1,000.

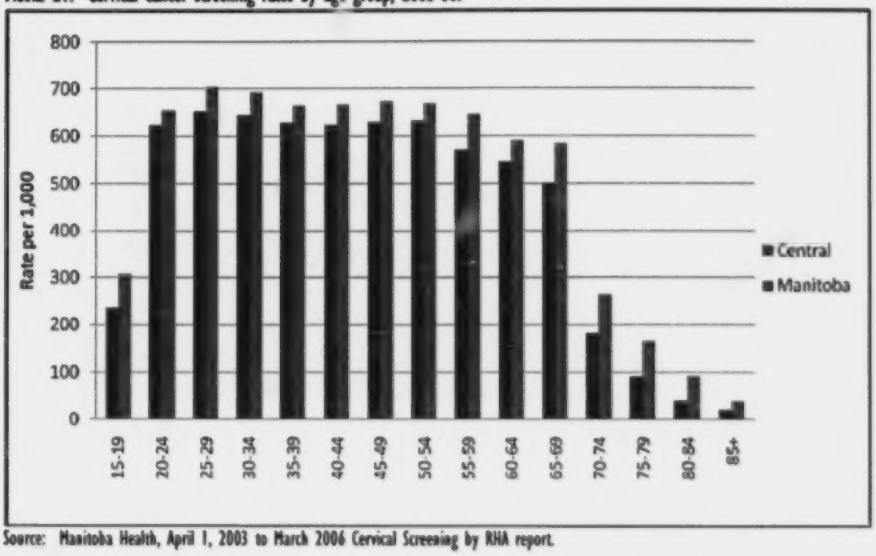
FIGURE 20. Cervical cancer screening rates by regional health authority, 2000-03 and 2003-06.



Source: Manitoba Health, April 2000-March 31, 2003 and April 1, 2003 to March 2006 Cervical Screening by RHA reports.

FIGURE 21 shows that cervical cancer screening rates remain lower than provincial screening rates in every age group. We can also see that young women between the ages of 15 and 19 and elderly women age 70 and older are much less likely to be screened for cervical cancer than are women in other age groups.

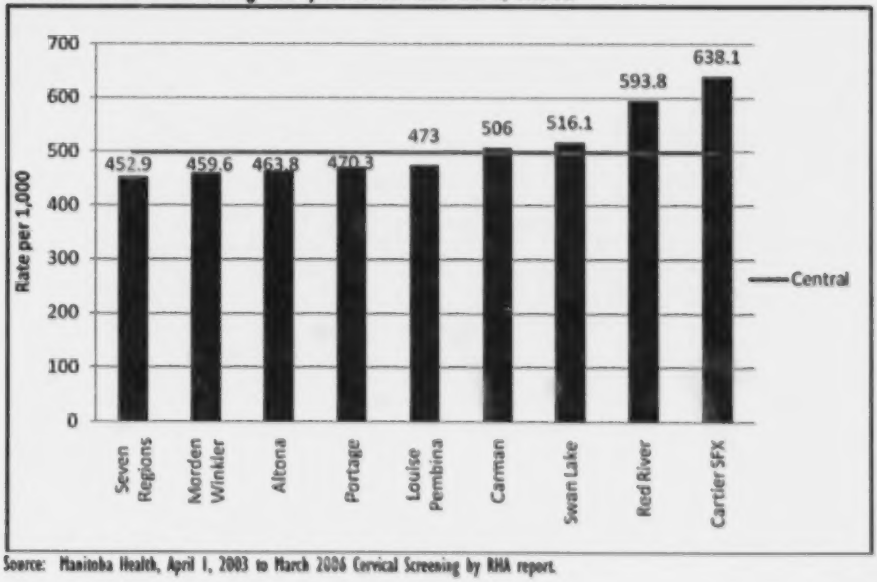
FIGURE 21. Cervical cancer screening rates by age group, 2003-06.



Source: Manitoba Health, April 1, 2003 to March 2006 Cervical Screening by RHA report.

Within Central Region, cervical cancer screening rates ranged from a low of 452.9 in Seven Regions to a high of 638.1 in the Cartier/St. François Xavier district. Red River and Cartier/St. François Xavier are the only two districts in our Region with screening rates exceeding the provincial average of 556.9 per 1,000.

FIGURE 22. Cervical cancer screening rates by RHA Central health district, 2003-06.



Source: Manitoba Health, April 1, 2003 to March 2006 Cervical Screening by RHA report.

Performance Measure BREAST CANCER SCREENING

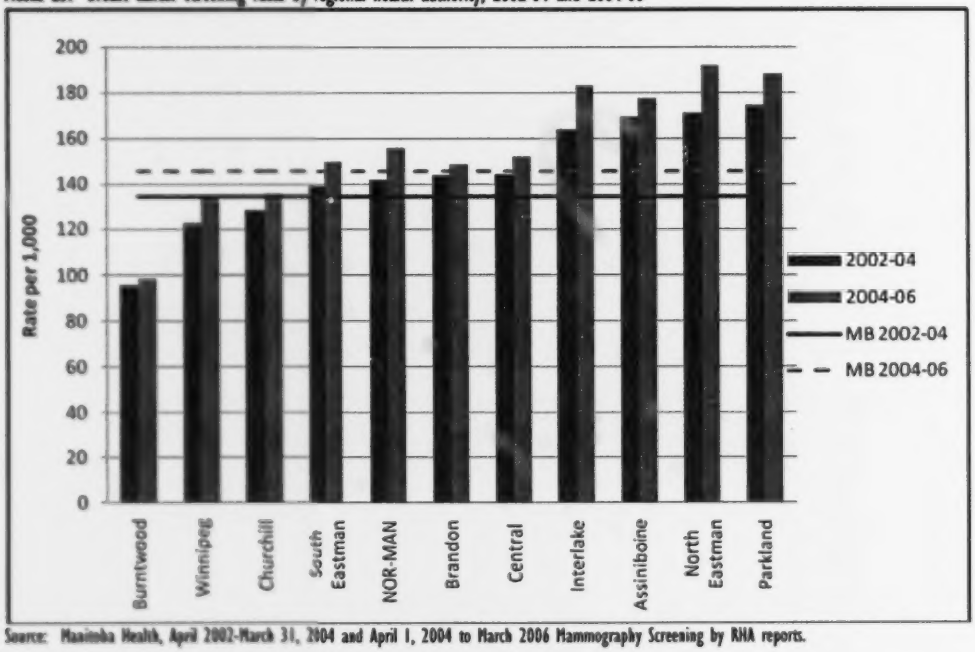
Significance of this Measure

Mammography screening with or without clinical breast examination has been shown in randomized trials to reduce the chance of dying of breast cancer. Screening for breast cancer is important as most women diagnosed with breast cancer do not have identifiable risk factors such as a family history of breast cancer.

Performance Highlights

FIGURE 23 shows breast cancer screening rates for two time periods: April 1, 2002 to March 31, 2004 and April 1, 2004 to March 31, 2006. Screening rates in Central Region increased very slightly between the two time periods from 144.3 per 1,000 women age 20 and older in the first time period to 152.0 in the second. Provincial rates also increased slightly in this period from 134.4 to 145.5 per 1,000 women age 20 and older.

FIGURE 23. Breast cancer screening rates by regional health authority, 2002-04 and 2004-06

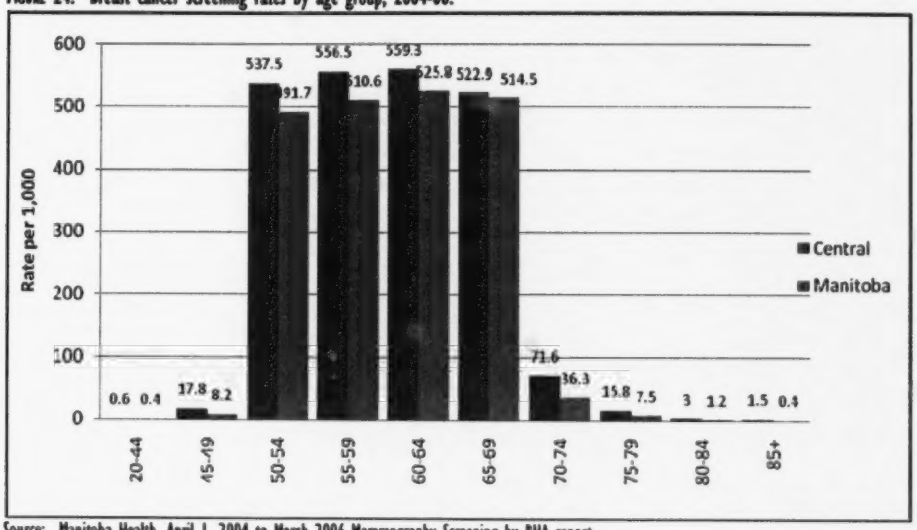


Source: Manitoba Health, April 2002-March 31, 2004 and April 1, 2004 to March 2006 Mammography Screening by RHA reports.

FIGURE 24 shows that breast cancer screening rates are slightly higher than provincial screening rates in every age group. It is also apparent that the greatest amount of screening activity is in the target age groups between 50 and 59. In these target age groups, over half of RHA Central women have had a screening mammogram.

Woman are encouraged to utilize the breast screening program which visits communities in RHA Central.

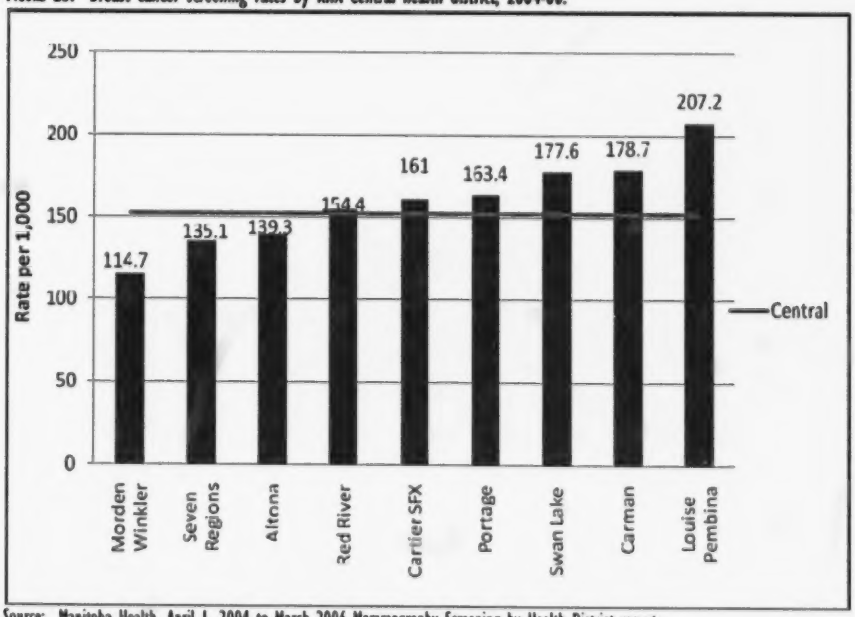
FIGURE 24. Breast cancer screening rates by age group, 2004-06.



Source: Manitoba Health, April 1, 2004 to March 2006 Mammography Screening by RHA report.

Within Central Region, breast cancer screening rates ranged from a low of 114.7 in Morden/Winkler to a high of 207.2 in Louise/Pembina Health District.

FIGURE 25. Breast cancer screening rates by RHA Central health district, 2004-06.



Source: Manitoba Health, April 1, 2004 to March 2006 Mammography Screening by Health District report.

Men are AS HEALTHY AS THEY CAN BE

The overall purpose of RHA Central is to provide services and programs to assist "men in Central Region to be as healthy as they can be". To achieve that END, the Board has set targets or priorities by which to measure outcomes. Following are some of those priorities, measures along with the outcomes and achievements for 06/07.

Board END

- Men do not suffer or die from preventable injuries
  - Men will make informed choices related to high-risk activities
- Men will have good mental health
- Men are free from addictions
- Men are educated and employed to their full potential
- Men will access services when they need them.

2006-07 Performance Measures

- Contact with physician
- Injury
- Heavy drinking
- Treatment prevalence for substance abuse disorders.

Performance Measure CONTACT WITH A PHYSICAN

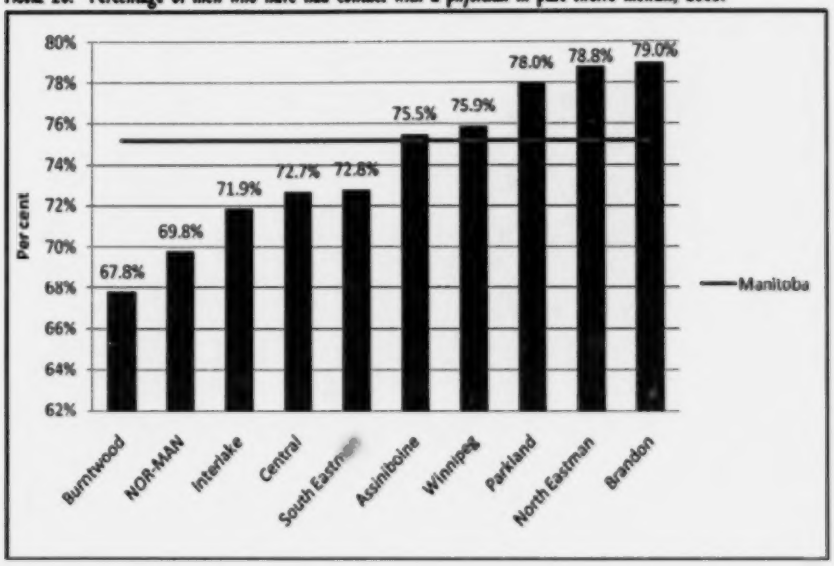
Significance of this Measure

Lack of contact with a medical doctor can happen for a variety of reasons, including lack of necessity to see a physician. However, lack of contact can also occur for a variety of reasons including unavailability of physicians, lack of willingness to visit a physician or inappropriate use of other services – such as emergency rooms – for issues that should be addressed by a regular visit to a medical doctor. A visit to a medical doctor at least once every twelve months can also be beneficial to preventing the onset of illness for which a patient may be at risk as well as for identifying illnesses in very early stages.

Performance Highlights

Within our Region, just over 87 per cent of residents living off-reserve visit their physician at least once in a twelve-month period. However, the rate is much lower for Central Region men at 72.7 per cent compared to women at 81.1 per cent. FIGURE 26 shows that the regional rate of visits to physicians by males is amongst the lowest in the Province.

FIGURE 26. Percentage of men who have had contact with a physician in past twelve months, 2005.



Source: Canadian Community Health Survey, Cycle 3.1 (2005).
Note: Off-reserve data only.

Performance Measure INJURY THAT LIMITS ACTIVITIES

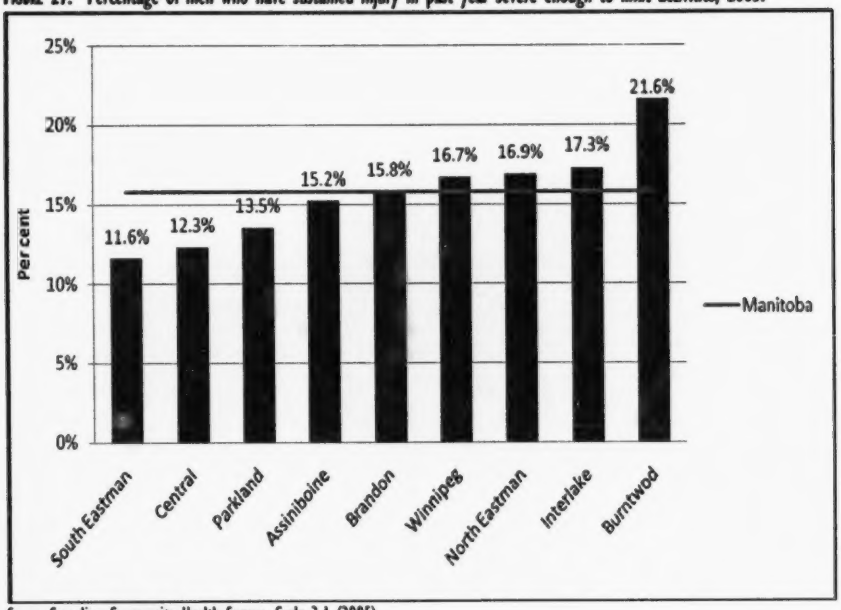
Significance of this Measure

The disparity in life expectancy and mortality rates between men and women is partly due to deaths due to injury among young men. Unintentional injury is also accountable for a large number of hospitalizations and physician visits among young men compared.

Performance Highlights

In Central Region, 12.3 per cent of men (age 12 and older) report sustaining an injury in the past twelve months that was severe enough to limit activities. This is the second lowest rate in the Province and is lower than the provincial rate of 15.8 per cent. Central Region rates of injury among males appear to be decreasing over time – rates of 14.4 per cent and 18.8 per cent were previously reported in 2000/01 and 2003 respectively. Note that repetitive strain injuries are not included in this definition.

FIGURE 27. Percentage of men who have sustained injury in past year severe enough to limit activities, 2005.



Source:Canadian Community Health Survey, Cycle 3.1 (2005).
Note: Off-reserve data only.
Note 2: NOR-MAN data suppressed by Statistics Canada.

Performance Measure HEAVY DRINKING

Significance of this Measure

Moderate and responsible drinking among adults is not an issue of concern to health care providers. However, there are many effects of heavy drinking. The short term and obvious effects include injuries or death due to risky behaviours (such as drunk driving). There are also many long term health effects from long term heavy drinking patterns. Drinking heavily over a long period of time is associated with:

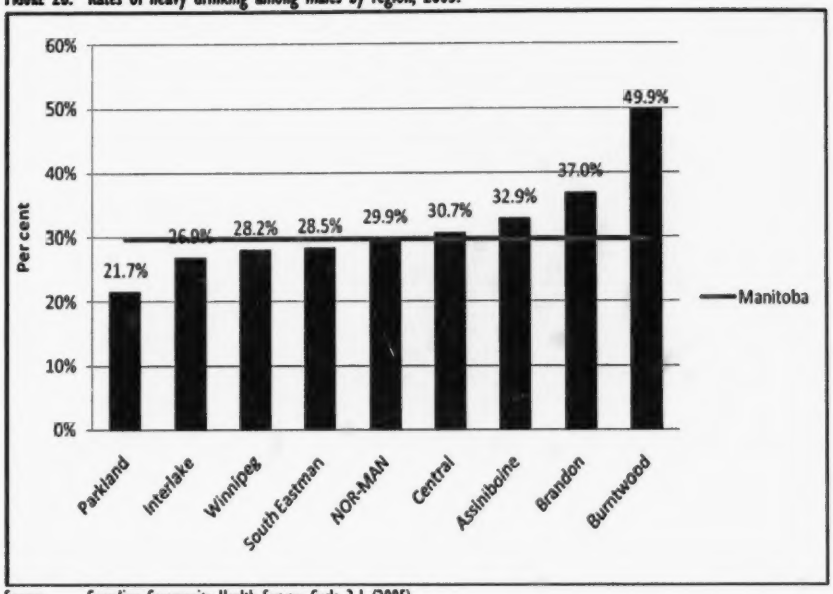
- stomach ulcers
- sexual problems
- liver disease
- brain damage
- certain types of cancer.

The Canadian Community Health Survey defines "heavy drinking" as having 5 or more drinks on 12 or more occasions.

Performance Highlights

In 2005, 30 per cent of Central Region men who drink alcohol meet the criteria for "heavy drinking". This number does not include men living on reserve so the true rate of heavy drinking in our Region may be higher than this. Our rate is very similar to the provincial rate but it is the third highest in the Province (see FIGURE 28).

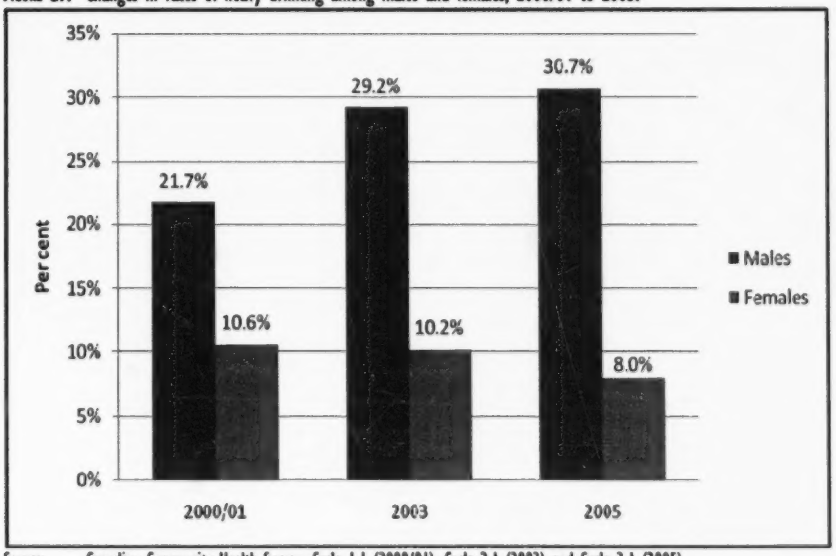
FIGURE 28. Rates of heavy drinking among males by region, 2005.



Source: Canadian Community Health Survey, Cycle 3.1 (2005).
Note: Off-reserve data only.
Note 2: North Eastman data not available.

FIGURE 29 examines changes over time in heavy drinking rates among Central Region residents. While rates of heavy drinking among women have remained at about 10 per cent or less, rates of heavy drinking among men has increased from 21.7 per cent in 2000/01 to 30.7 per cent in 2005.

FIGURE 29. Changes in rates of heavy drinking among males and females, 2000/01 to 2005.



Source: Canadian Community Health Survey, Cycle 1.1 (2000/01), Cycle 2.1 (2003) and Cycle 3.1 (2005).
Note: Off-reserve data only.

Performance Measure MENTAL HEALTH

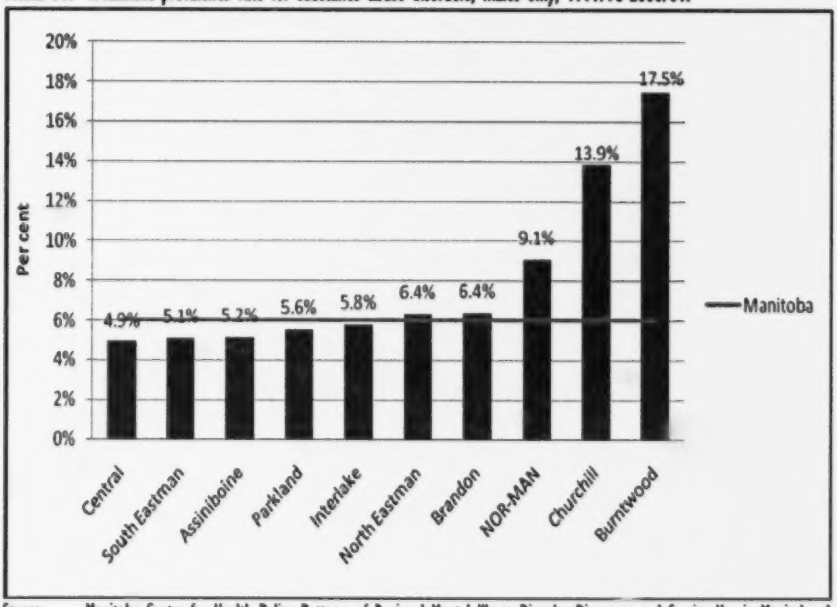
Significance of this Measure

Substance abuse results from the repeated intake of alcohol, illegal drugs or prescription medicines until a physical and/or psychological dependence develops. Factors that may lead to substance abuse include troubled relationships (romantic or family), financial difficulties, significant changes in one's life, and peer pressure. Some research noted that there may be a genetic predisposition for the development of a substance abuse problem. Men are approximately five times more likely than women to have a substance abuse problem.

Performance Highlights

The treatment prevalence rate for substance abuse disorders among Central Region males is the lowest in the Province at 4.9 per cent of all males age 10 and older. This is statistically lower than the provincial average of 6.0 per cent (see FIGURE 30).

FIGURE 30. Treatment prevalence rate for substance abuse disorders, males only, 1997/98-2000/01.



Source: Manitoba Centre for Health Policy Patterns of Regional Mental Illness Disorder Diagnoses and Service Use in Manitoba: A Population-Based Study (November 2004).

Seniors are As HEALTHY AS THEY CAN BE

The overall purpose of RHA Central is to provide services and programs to assist "seniors in Central Region to be as healthy as they can be". To achieve that END, the Board has set targets or priorities by which to measure outcomes. Following are some of those priorities, measures along with the outcomes and achievements for 06/07.

Board END

- Seniors remain independent and active as long as possible
- Seniors experience an optimal quality of life
  - Seniors are free from abuse
- Seniors live in their community of choice
  - Seniors utilize housing appropriate to their needs
- Seniors have support in their care-giving role
- Seniors receive respect and appropriate care from their children and/or their community.

Strategic Priorities

Reduce falls/injuries and resulting hospitalizations related to unsafe conditions in living environment

Some of our results

- Planning to add more locations to offer the 'Safety Aid Program' (currently in Portage and Gladstone)
- Implementing a 'Falls Management Program' for clients at risk
- Fall prevention pamphlet information available:
  - For community members
  - For personal care home clients and families
  - Regarding selecting appropriate footwear
- Annual audit completed on compliance with restraint policy in personal care homes. 72% compliant 06. Target is 80% compliance
- Personal care home annual average rate of falls
  - 2005/06 = 11 falls/1,000 client days
  - 2006/07 = 8 falls/1,000 client days.

Caregivers will feel supported with care in the home and appropriate clients will remain in their home environment

Some of our results

- Developing client satisfaction survey for home care clients
- Contact guide of available resources for seniors has been developed and implemented by Services to Seniors.

Increase public and employee awareness of elder abuse and decrease the incidence of elder abuse among those clients receiving care provided by RHA staff

Some of our results

- 'Zero Tolerance for Abuse' policy implemented 2005
- Since then 1,079 staff educated
- Policy education a part of regional orientation
- Elder abuse guide developed & implemented
- 94% of Services to Seniors programs have distributed guides.

Increase affordable housing options for seniors with appropriate supports relevant to their needs.

2006-07 Performance Measures

In the summer and early fall of 2006, RHA Central held focus groups with seniors in our Region as part of the Board's ownership linkage commitment.

Performance Highlights

Focus Group Dates and Participants

Focus Group Date	Focus Group Location	Number of Attendees
June 20, 2006	St. Claude	7
June 21, 2006	Gladstone	10
June 26, 2006	Darlingford	5
June 27, 2006	Portage - FN	1
September 20, 2006	Gretna	4

- A total of 27 participants
- 7 participants were men (26%)

Some of the highlights from the focus groups with seniors

- Many people defined "independence" as remaining in their own home and being able to look after themselves and their homes.
- Many participants talked about the importance of friends and family as being key to their independence.
- Being active was seen as a way to socialize and to keep mentally well.
- "Being active means not feeling old."
- Many participants mentioned the need for communities to ensure that they provide services to seniors so that seniors can stay in the community.
- Need for excellence in palliative care both in the hospital and in the home was a very important issue to participants.
- Need for spiritual care services was mentioned by many participants.
- Social and spiritual supports were mentioned as being key to staying healthy.

At a reasonable cost to the community

The overall purpose of RHA Central is to provide services and programs to assist "the community in Central Region to be as healthy as they can be". To achieve that END, the Board has set targets or priorities by which to measure outcomes. Following are some of those priorities, measures along with the outcomes and achievements for 06/07.

Board END

- Services provided are aligned with all the resources available to the Region (i.e. fiscal, human and physical).
- Our health care system is sustainable when it
  - Provides the appropriate level of care in response to population needs of the day
  - Has the capability to adapt or adjust to new and evolving realities
- Efforts in our health care system optimize an increased sense of personal responsibility for wellbeing across time
- People in Central Region have timely access to medically necessary care
- People in Central Region can expect the most appropriate care, by the most appropriate providers, in the most appropriate settings.

2006-07 Performance Measures

This Board END was articulated during fiscal year 2006-07. The following are Sample Performance Measures

- Rates of physicians
- Access to a regular medical doctor
- Ambulatory Care Sensitive Conditions
- Wait times for hip fracture surgery.

Performance Measure RATES OF PHYSICIANS

Significance of this Measure

Physician to population ratios are used to support health human resource planning. While these ratios are useful indicators of changes in physician numbers relative to the population, we must be cautious in using these ratios alone to decide if our Region is adequately resourced.

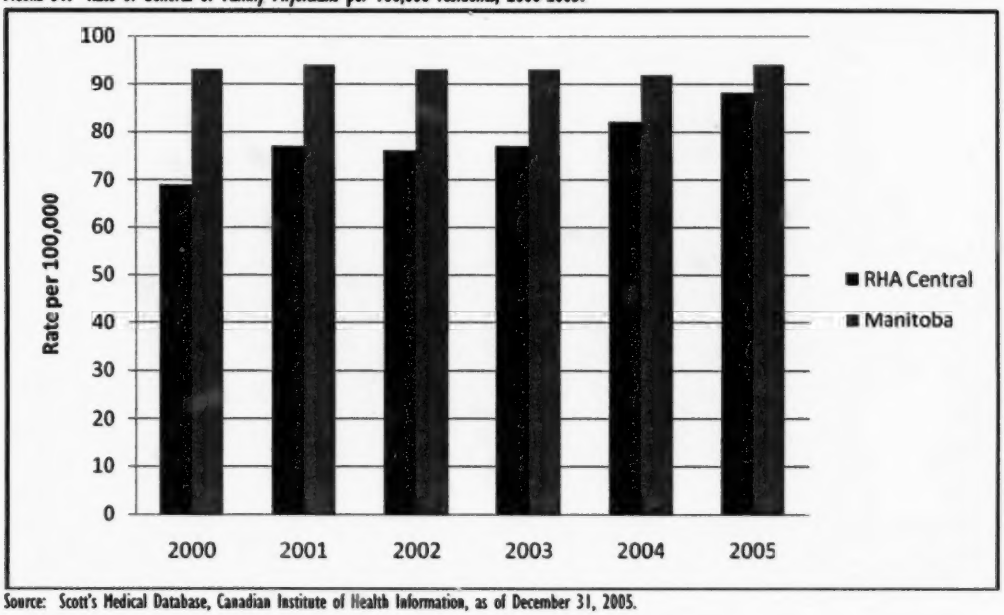
Many factors influence whether the supply of physicians is appropriate, such as: distribution and location of physicians within the Region; physician type; level of service provided (full-time vs. part-time); physician age and gender; population's access to hospitals, health care facilities, technology and other types of health care providers as well as population needs.

In some regions, health facilities and personnel provide services to a larger community than the residents of the immediate region. In others, residents may seek care from physicians and specialists outside the region where they live. The ratio of physicians to population reflects the number of doctors in a region and has not been adjusted to take these movements into account. The extent to which this affects individual regions is likely to vary but in our Region, we know for example, that in communities that are very close to Winnipeg, residents are likely to see a physician in Winnipeg.

Performance Highlights

Although rates of general and family physicians have remained lower than the provincial rates in the six-year time period examined, the positive news is that rates in our Region are consistently increasing. Rates of family physicians have increased from 69 per 100,000 in 2000 to 88 per 100,000 in 2005. While regional rates have continued to increase, provincially rates of family physicians have remained quite steady at between 92 and 94 physicians per 100,000 residents (see FIGURE 31). These rates are calculated as of December 31 of each calendar year.

FIGURE 31. Rate of General or Family Physicians per 100,000 residents, 2000-2005.



Source: Scott's Medical Database, Canadian Institute of Health Information, as of December 31, 2005.

Performance Measure REGULAR MEDICAL DOCTOR

Significance of this Measure

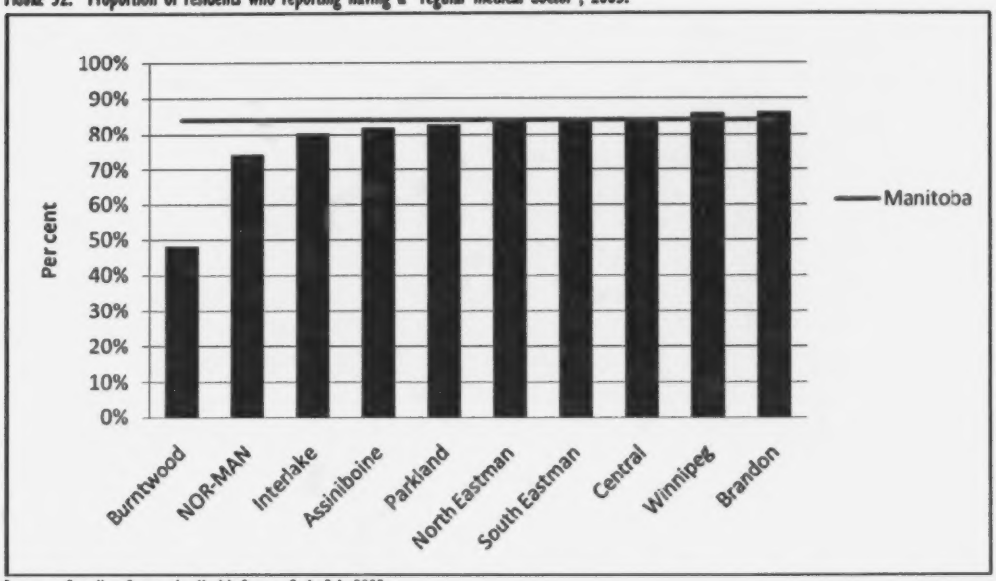
Establishing an ongoing relationship with a regular medical doctor is believed to be important in maintaining health and ensuring appropriate access to health services.

Information regarding whether residents have a regular medical doctor is available from the 2005 Canadian Community Health Survey. Respondents were considered not to have looked for a regular medical doctor if their responses included "Have not tried to contact one" or "Other reasons". All other respondents without a regular medical doctor were considered to have been unable to find one. Their responses included various combinations of the following: "No medical doctors available in the area", "Medical doctors in the area are not taking new patients" and "Had a medical doctor who left or retired".

Performance Highlights

Just under 84 per cent of RHA Central residents (over age 12) report having a "regular medical doctor". This rate is identical to the provincial rate and is not different from rates seen in the larger urban centres of Winnipeg and Brandon. This would indicate that although we have a lower rate of physicians per capita than is the case in Winnipeg and Manitoba overall, residents are able to find a medical doctor and have an ongoing relationship with that physician. It is also important to note that while, 15.7 per cent of residents indicated that they do not have a regular medical doctor, 10.9 percent don't have a regular doctor "because they have not looked for one" and only 4.6 per cent of respondents were "unable to find a family doctor".

FIGURE 32. Proportion of residents who reporting having a "regular medical doctor", 2005.



Source: Canadian Community Health Survey, Cycle 3.1, 2005.
NOTE: Off-reserve data only.

Performance Measure AMBULATORY CARE CONDITIONS

Significance of this Measure

Ambulatory Care Conditions are conditions where disease management on an outpatient or community basis can prevent hospitalization. These conditions include:

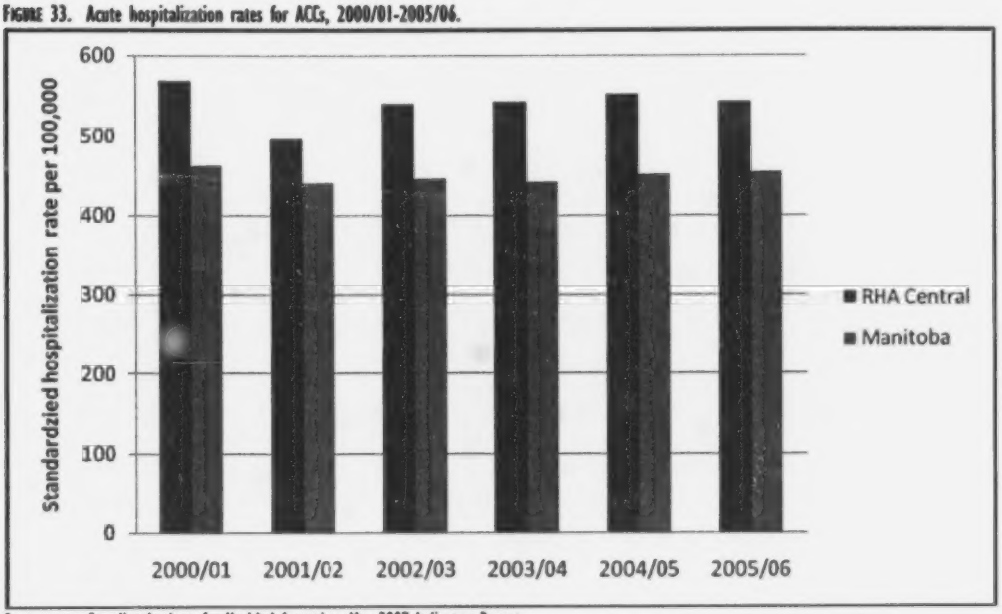
- grande mal seizures or other epileptic seizure
- chronic obstructive pulmonary disease (COPD)
- angina,
- congestive heart failure
- diabetes
- hypertension
- asthma.

It is important to note that not all admissions for ACCs are avoidable. However, appropriate community-based care can often assist in preventing the onset of certain illnesses or conditions, controlling an acute episodic illness or condition, or managing a chronic disease. For example, many people have asthma but with proper control of the asthma, patients may avoid acute asthma attacks and subsequent emergency department visits and hospitalizations.

Performance Highlights

As FIGURE 33 shows, hospitalization rates for ACCs have consistently remained higher than provincial rates. However, rates have declined slightly between 2000 and 2005 from 568 hospitalizations per 100,000 to 542 hospitalizations per 100,000.

FIGURE 33. Acute hospitalization rates for ACCs, 2000/01-2005/06.



Source: Canadian Institute for Health Information, May 2007 Indicators Report.

Performance Measure WAIT TIME FOR HIP FRACTURE SURGERY[3]

Significance of this Measure

Operative delay in older patients with the hip fracture is associated with higher risk of postoperative complications and death. Wait time for surgery following hip fracture provides a measure of the access of care. It is important to note that wait times may be influenced by other health conditions, hospital transfers and practice differences related to certain types of medication, like blood thinners. However, longer waits may indicate lack of resources or physician unavailability. In December 2005, a benchmark of hip fracture fixation within 48 hours was set by Federal, Provincial and Territorial governments.

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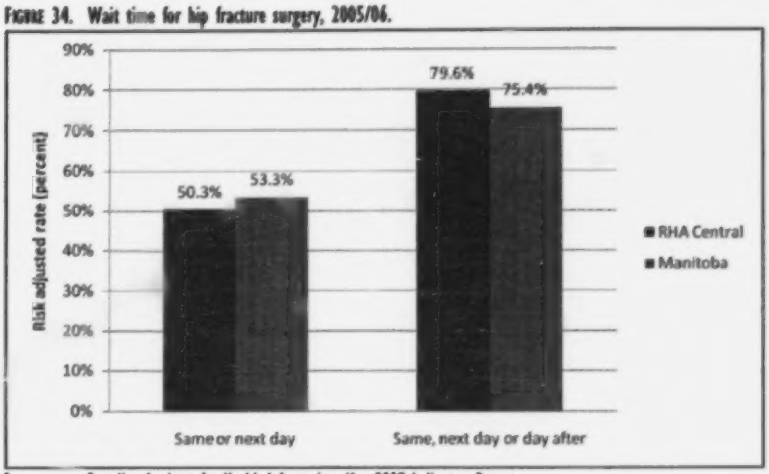
[3] **Proportion with surgery same or next day:** Risk-adjusted proportion of hip fracture patients aged 65 and older who underwent hip fracture surgery on the day of admission or the next day.
Proportion with surgery same, next day or day after: Risk-adjusted proportion of hip fracture patients aged 65 and older who underwent hip fracture surgery on the day of admission, the next day or the day after that.

Performance Highlights

As FIGURE 34 shows, 50.3 per cent of Central Region residents who were admitted to an acute care hospital for hip fracture surgery, were operated on that same day or the next day. Overall, 75 per cent of Central Region residents were operated on within 2 days (which is considered to be equivalent to the 48-hour benchmark as exact times of surgeries are not recorded). These rates are very similar to the provincial rates.

FIGURE 34. Wait time for hip fracture surgery, 2005/06.



Source: Canadian Institute for Health Information, May 2007 Indicators Report

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[i] Alberta Health and Wellness. Health Information – Preventing Diseases: Alberta Immunization Program. http://www.health.gov.ab.ca/public/imm_program.html

[ii] Ibid.

[iii] Ibid.

[iv] Substance Abuse and Mental Health Services Administration, (SAMHSA), HHS, Calculated based on data in National Household Survey on Drug Abuse, 2001. http://oas.samhsa.gov/facts.cf

[v] Hofferth SL. Social and economic consequences of teenage childbearing. In: Hofferth SL, Hayes CD, eds. Risking the future: adolescent sexuality, pregnancy and childbearing. Washington, DC: National Academy Press; 1987;2:123-44.

[vi] Brown HL, Fan YD, Gonsoulin WJ. (1991). Obstetric complications in young teenagers. South Med J;84:46-8.

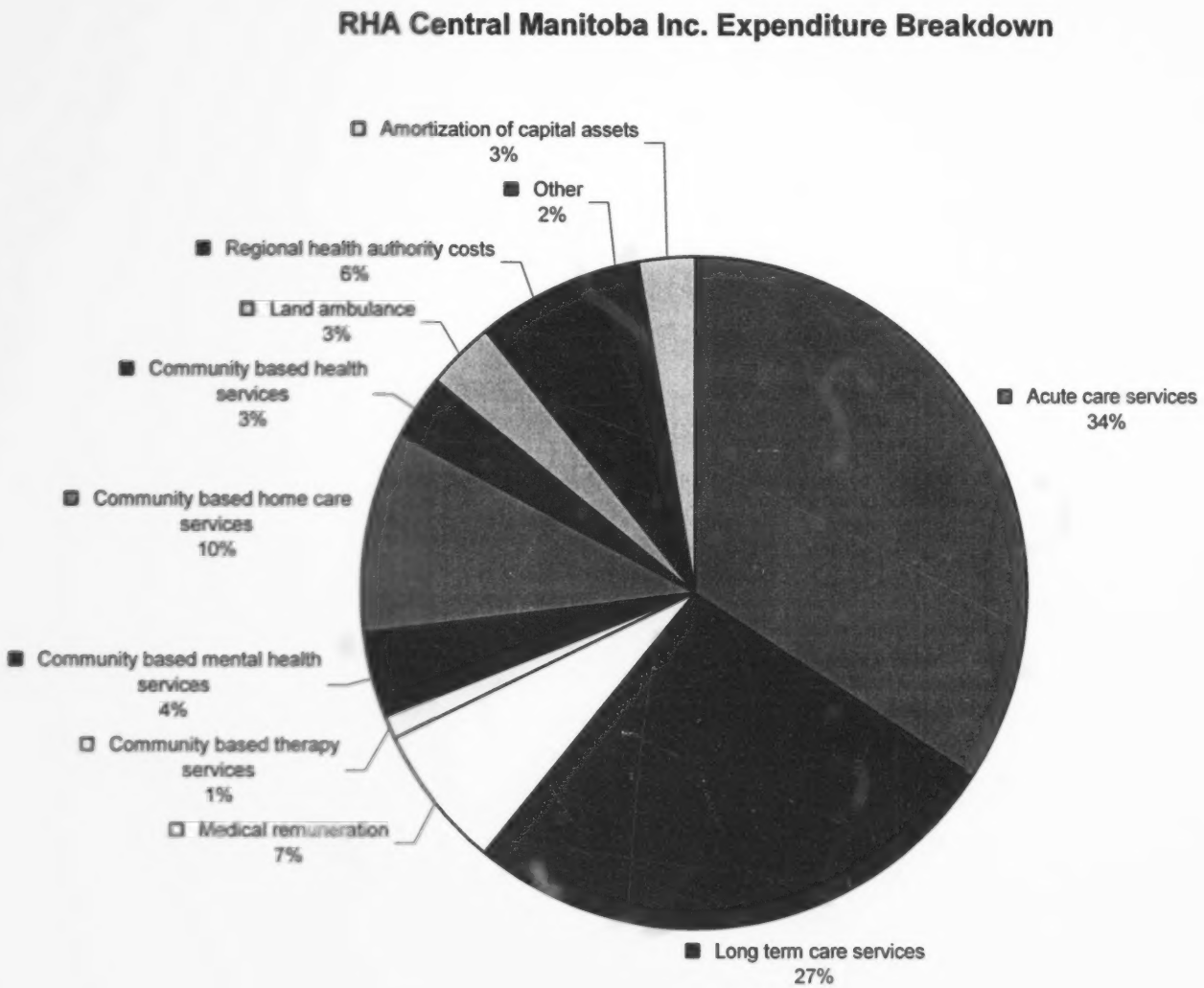
[vii] Stene, LC, Magnus, P, Lie, RT, Sovik, O, Joner, G. (2001).Birth weight and childhood onset type 1 diabetes: population based cohort study. British Medical Journal, 322, 889-892.

[viii] Background information on measuring readiness to learn announced in the speech from the throne September 23, 1997. http://socialunion.gc.ca/nca/nca5_e.html

[ix] Ibid.

Financial Highlights

2006-2007 Expenses



Financial Statements

STATEMENT OF FINANCIAL POSITION

	2007	2006
ASSETS		
CURRENT		
Cash and short term investments	$ 8,168,863	$ 7,052,227
Accounts receivable, net	2,018,612	1,182,781
Accounts receivable - Manitoba Health	2,428,803	1,945,523
Inventories	1,145,420	1,254,134
Prepaid expenses	876,549	782,976
Due from Manitoba Health - vacation entitlements	7,775,928	7,775,928
	22,414,175	19,993,569
NON-CURRENT		
Due from Manitoba Health - retirement entitlements	9,106,000	9,106,000
Capital assets	80,849,163	82,506,870
Other assets	157,787	154,700
	$ 112,527,125	$ 111,761,139
LIABILITIES, DEFERRED CONTRIBUTIONS AND NET ASSETS		
CURRENT		
Accounts payable and accrued liabilities	$ 10,440,211	$ 9,157,553
Accrued vacation entitlements	9,108,207	9,087,862
Current portion of long term debt	199,247	185, 071
	19,747,665	18,430,486
NON-CURRENT		
Accrued retirement entitlements	10,024,183	9,641,226
Long term debt	2,779,095	2,981,516
	12,803,278	12,622,742
DEFERRED CONTRIBUTIONS		
Expenses of future periods	2,710,162	2,560,833
Capital assets	76,526,493	77,765,873
	79,236,655	80,326,706
NET ASSETS		
Invested in capital assets	1,344,516	1,665,662
Contract facilities	1,219,624	966,821
Internally restricted	276,773	276,773
Unrestricted	(2,101,386)	(2,528,051)
	739,527	381,205
	$ 112,527,125	$ 111,761,139

STATEMENT OF OPERATIONS

	2007	2006
REVENUE		
Manitoba Health	$ 143,615,736	$ 133,589,373
Other government departments	297,197	1,335,383
Non-global patient and resident income	11,775,155	11,528,301
Other income	5,062,437	5,248,013
Amortization of deferred contributions – expenses of future periods	2,505,054	2,295,573
Amortization of deferred contributions - capital and foundations	4,358,692	4,376,623
Interest and donations	386,184	287,690
Ancillary operations	2,152,908	2,066,423
	170,153,363	160,727,379
EXPENSES		
Acute care services	57,983,832	56,481,830
Long term care services	44,941,633	43,017,691
Medical remuneration	11,778, 867	10,673,128
Community-based therapy services	2,109,889	1,893,466
Community-based mental health services	6,835,506	7,310,070
Community-based home care services	16,628,574	14,675,845
Community-based health services	5,220,212	6,063,690
Land ambulance	5,478,220	4,895,856
Regional Health Authority undistributed	9,795,784	9,467,185
Interest on long term debt	439,736	364,646
Pre-retirement leave	1,169,500	1,762,336
Amortization of capital assets	4,545,995	4,573,611
Major repairs	610,808	449,065
Donations to foundations	21,000	22,000
Ancillary operations	1,817,993	1,803, 543
	169,377,549	163,453,962
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	775,814	(2,726,583)
ALLOCATION OF EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES		
Capital and donations to foundations	$ (819,111)	$ (668,053)
Interest and donations	386,184	287,690
Ancillary operations	334,915	262,880
Health care operations	873,826	(2,609,100)
TOTAL	$ 775,814	$ (2,726,583)

A complete set of financial statements, auditor's reports and the statement of public sector compensation disclosure can be obtained from the Regional Health Authority – Central Manitoba Inc. by submitting a request letter to:

CHIEF EXECUTIVE OFFICER
REGIONAL HEALTH AUTHORITY – CENTRAL MANITOBA INC.
BOX 243, 180 CENTENNAIRE DRIVE
SOUTHPORT MB ROH 1NO

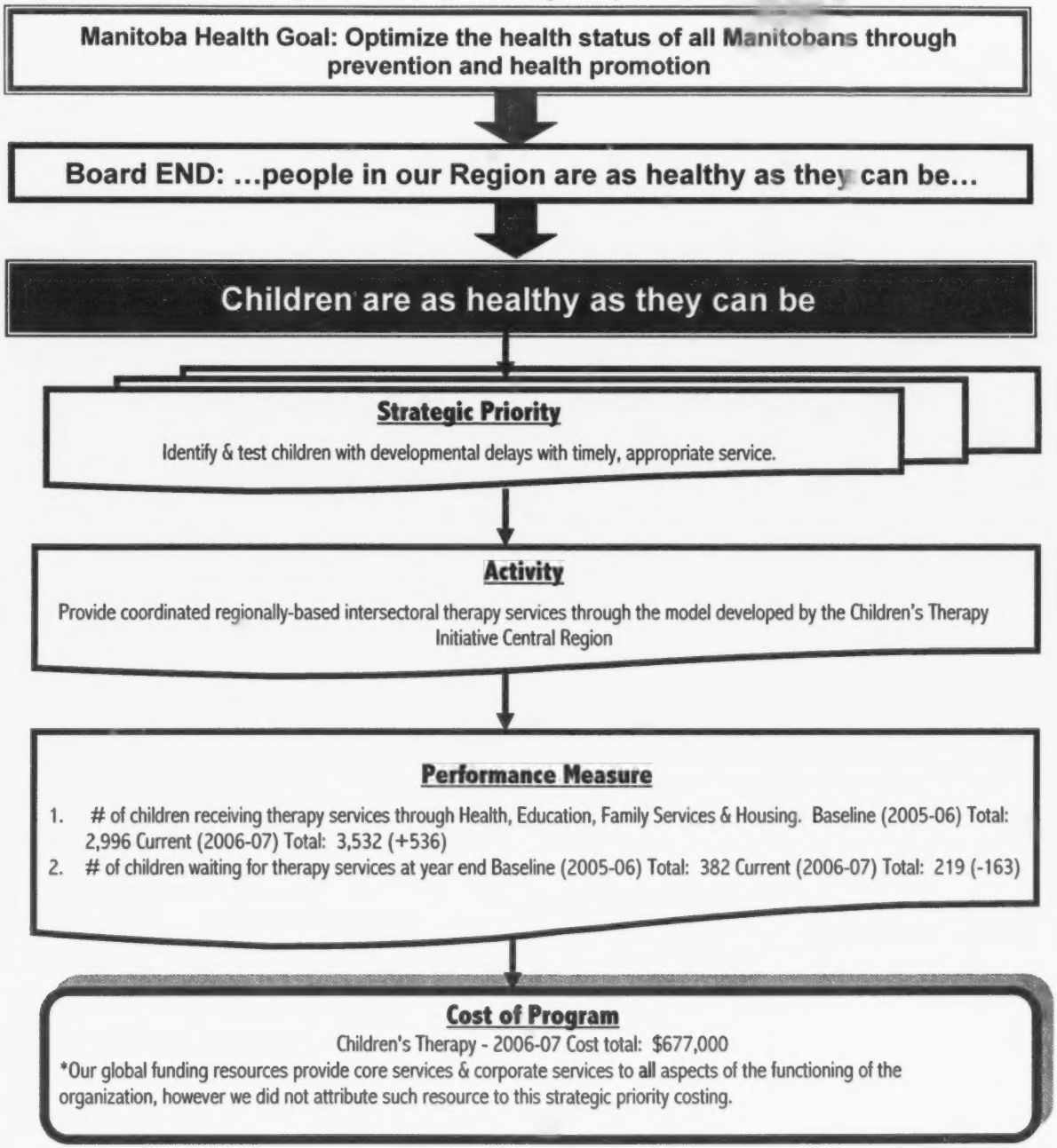
10 YEARS AGO . . .

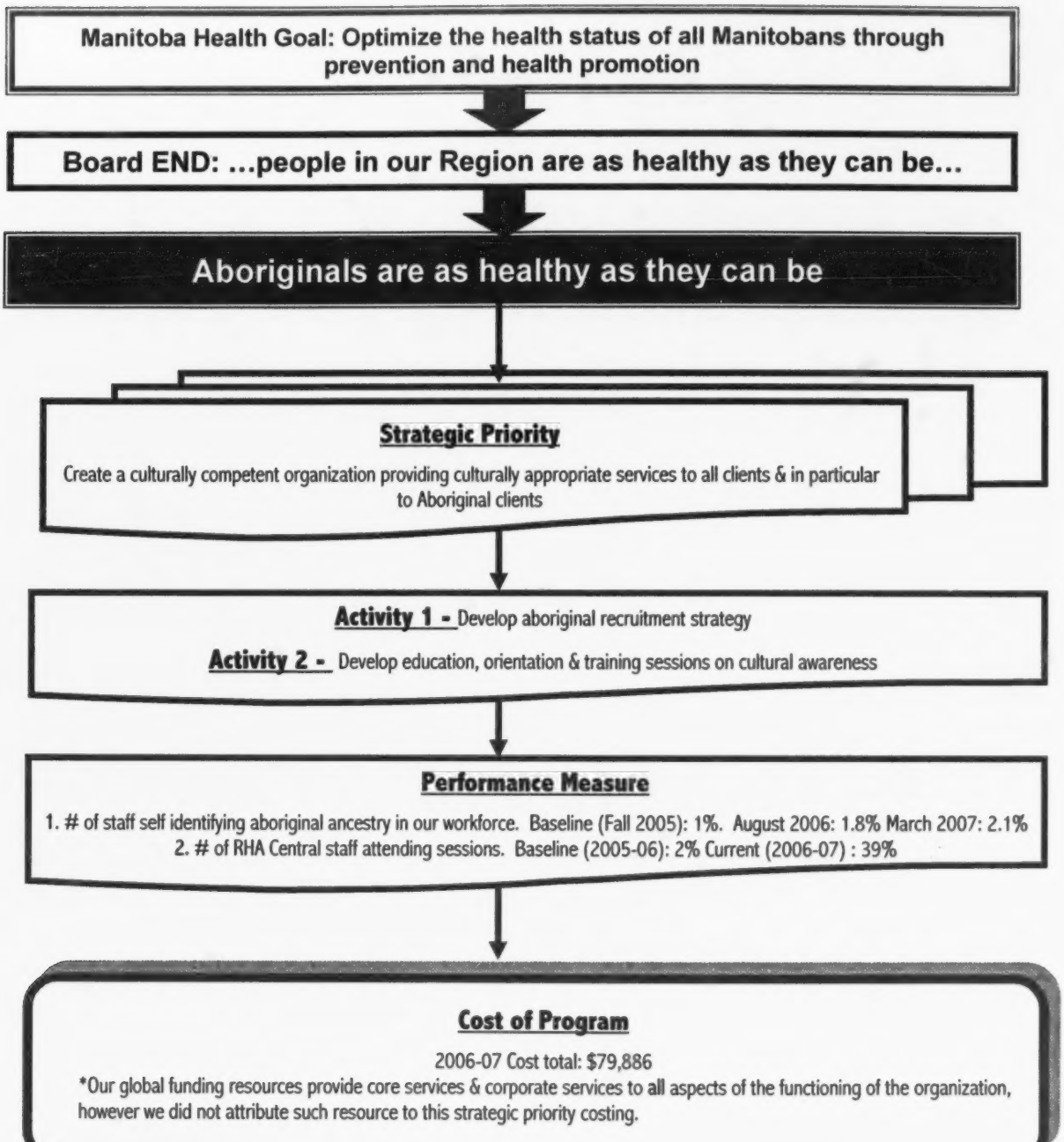
The financial beginnings of the RHA Central reflect a merging of figures for acute care, long term care, ambulance and other community services.

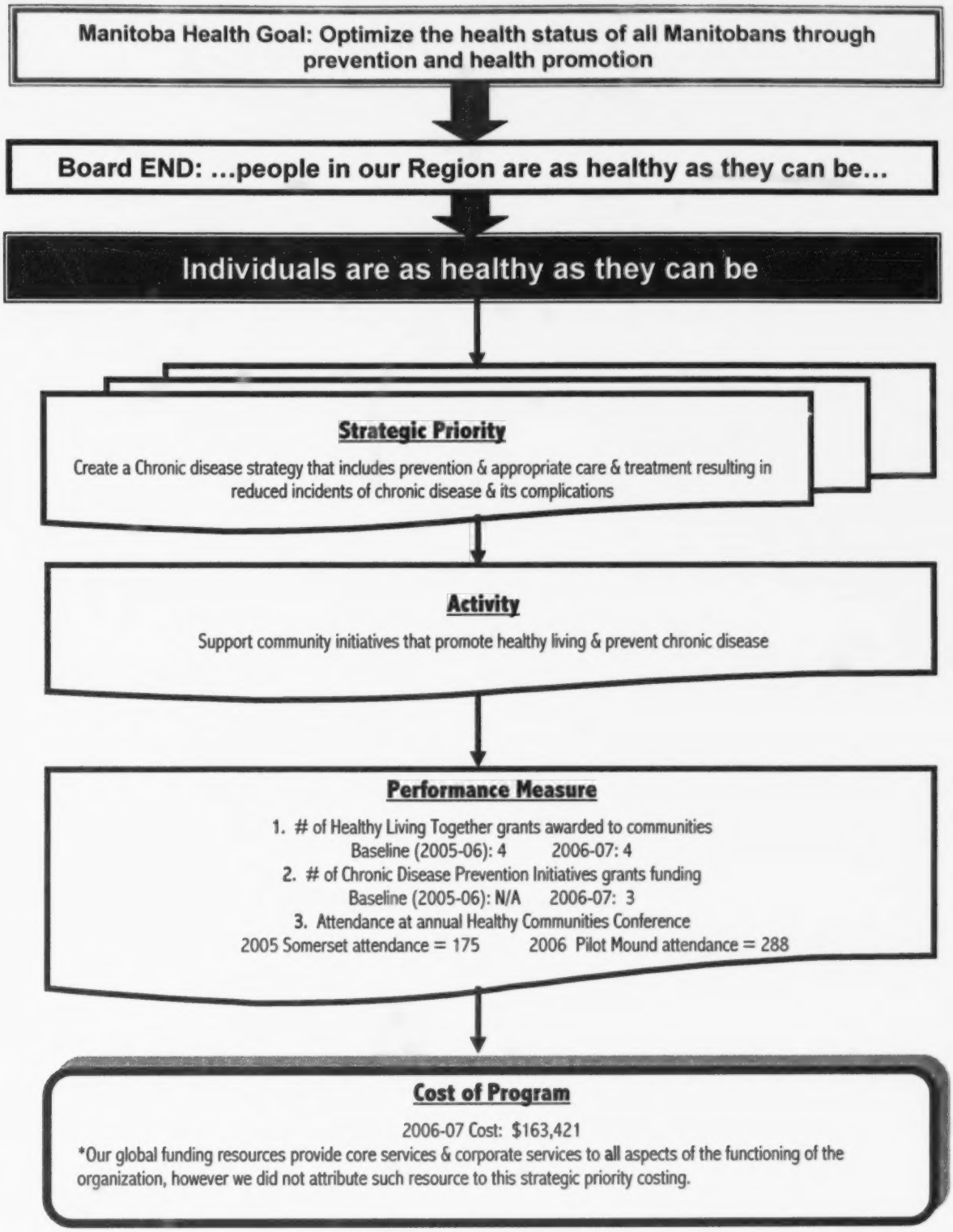
	1999	1998
REVENUE		
Manitoba Health	$ 81,225,109	$ 79,360,412
Other government departments	395,040	-
Non-insured income - acute	1,066,770	956,245
Residential income - long term care	9,217,582	9,326,368
Other income	2,658,059	3,484,093
Amortization of deferred contributions	3,202,447	2,278,769
Ancillary operations	2,115,804	2,150,810
	99,880,810	97,556,697
EXPENSES		
Acute care services	34,364,294	39,977,315
Long term care services	33,637,479	30,603,180
Medical remuneration	6,260,261	4,026,538
Therapy services	678,825	668,076
Community based mental health services	1,556,067	1,480,220
Community based home care services	8,757,871	8,769,212
Community based health services	3,887,480	3,866,640
Land ambulance	974,894	931,734
Regional health authority costs	3,221,904	678,927
Amortization of capital assets	3,036,570	2,543,447
Interest on long term debt	734,789	756,317
Major repairs	105,170	21,993
Other expenses - non-global	604,550	713,558
Donations to foundations	313,511	1,360,287
Ancillary operations	1,244,434	994,945
	99,378,098	97,392,389
OPERATING EXCESS OF REVENUES OVER EXPENSES	502,712	164,308
OTHER INCOME (EXPENSE)		
Gain on disposal of capital assets	-	491,747
Prior years funding adjustments	531,304	1,085,232
Other - contract facility transactions	(26,000)	(79,704)
	505,304	1,497,275
NET EXCESS OF REVENUES OVER EXPENSES	$ 1,008,016	$ 1,661,583

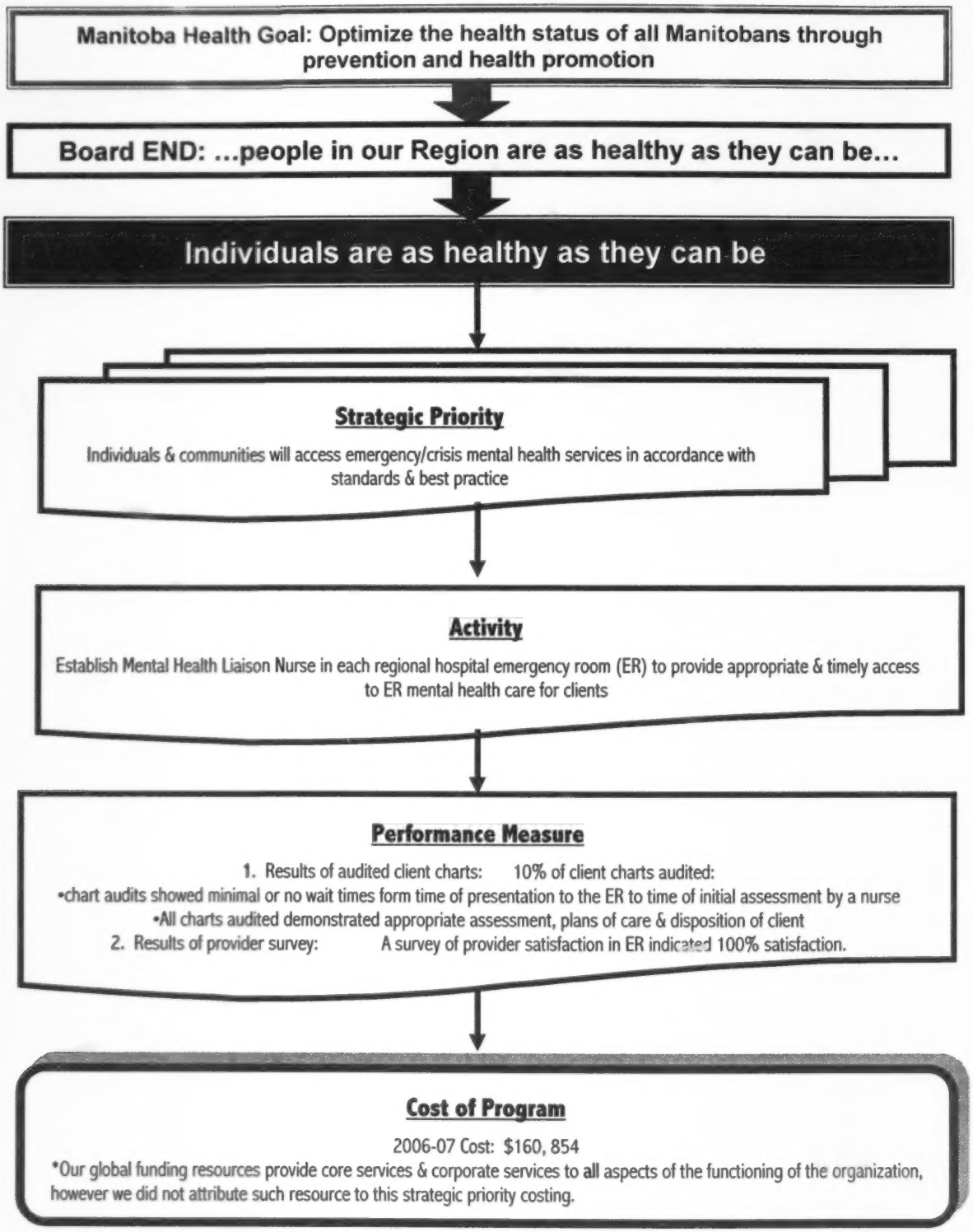
Linking Strategies, Activities and Results To Costs

For the first time in an annual report, we are pleased to report the association of program costs to budgetary distribution for some program areas. Due to the fact that program costs do overlap initiatives, figures may not be an exact representation.



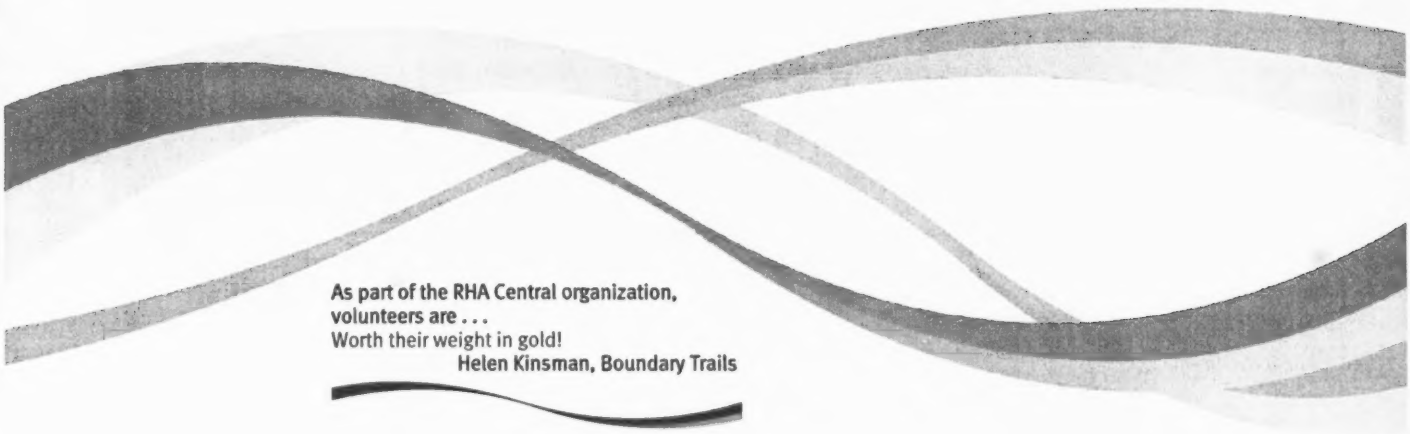

Manitoba Health Goal: Optimize the health status of all Manitobans through prevention and health promotion
Board END: ...people in our Region are as healthy as they can be...
Aboriginals are as healthy as they can be
Strategic Priority
Create a culturally competent organization providing culturally appropriate services to all clients & in particular to Aboriginal clients
Activity 1 - Develop aboriginal recruitment strategy
Activity 2 - Develop education, orientation & training sessions on cultural awareness
Performance Measure
1. # of staff self identifying aboriginal ancestry in our workforce. Baseline (Fall 2005): 1%. August 2006: 1.8% March 2007: 2.1%
2. # of RHA Central staff attending sessions. Baseline (2005-06): 2% Current (2006-07) : 39%
Cost of Program
2006-07 Cost total: $79,886
*Our global funding resources provide core services & corporate services to all aspects of the functioning of the organization, however we did not attribute such resource to this strategic priority costing.


Manitoba Health Goal: Optimize the health status of all Manitobans through prevention and health promotion
Board END: ...people in our Region are as healthy as they can be...
Individuals are as healthy as they can be
Strategic Priority
Create a Chronic disease strategy that includes prevention & appropriate care & treatment resulting in reduced incidents of chronic disease & its complications
Activity
Support community initiatives that promote healthy living & prevent chronic disease
Performance Measure
1. # of Healthy Living Together grants awarded to communities
Baseline (2005-06): 4 2006-07: 4
2. # of Chronic Disease Prevention Initiatives grants funding
Baseline (2005-06): N/A 2006-07: 3
3. Attendance at annual Healthy Communities Conference
2005 Somerset attendance = 175 2006 Pilot Mound attendance = 288
Cost of Program
2006-07 Cost: $163,421
*Our global funding resources provide core services & corporate services to all aspects of the functioning of the organization, however we did not attribute such resource to this strategic priority costing.


Manitoba Health Goal: Optimize the health status of all Manitobans through prevention and health promotion
Board END: ...people in our Region are as healthy as they can be...
Individuals are as healthy as they can be
Strategic Priority
Individuals & communities will access emergency/crisis mental health services in accordance with standards & best practice
Activity
Establish Mental Health Liaison Nurse in each regional hospital emergency room (ER) to provide appropriate & timely access to ER mental health care for clients
Performance Measure
1. Results of audited client charts: 10% of client charts audited:
•chart audits showed minimal or no wait times form time of presentation to the ER to time of initial assessment by a nurse
•All charts audited demonstrated appropriate assessment, plans of care & disposition of client
2. Results of provider survey: A survey of provider satisfaction in ER indicated 100% satisfaction.
Cost of Program
2006-07 Cost: $160, 854
*Our global funding resources provide core services & corporate services to all aspects of the functioning of the organization, however we did not attribute such resource to this strategic priority costing.

As part of the RHA Central organization, volunteers are . . .
Very crucial for a lot of communities with a lot of elderly patients

Sameh Fikry, St. Claude



As part of the RHA Central organization, volunteers are . . .
Worth their weight in gold!

Helen Kinsman, Boundary Trails

As part of the RHA Central organization, volunteers are . . .
A very important part of helping the RHA deliver quality health care in our Region.

Martin Montanti, Portage la Prairie

Regional Health Authority
Central Manitoba Inc.

Office régional de la santé
du Centre du Manitoba inc.

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